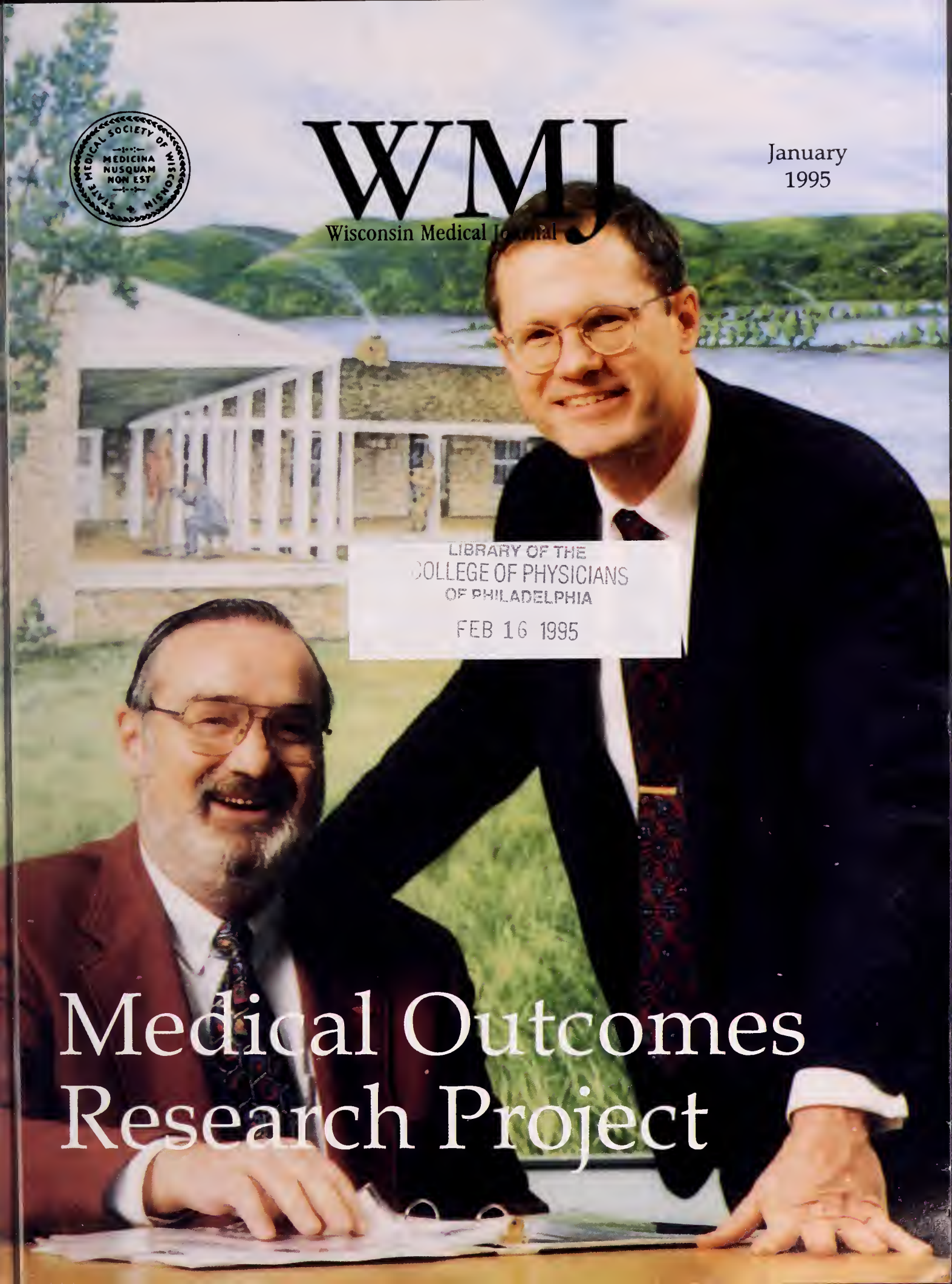

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Wisconsin Medical Journal

January
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State Medical Society of Wisconsin

Created by the Territorial Legislature in 1841 and now representing nearly 7,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal*.

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Our cover: Richard Edwards, MD, (l) chair of the PIC Wisconsin Board of Directors, and William Montei, (r) president and CEO of PIC, join forces to enhance the CESF Medical Outcomes Research Project. Our theme stories can be found on pages 27, 31, 33, 37 and 39.

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President's page

Medicine's next challenge: Answering the value question

The end of medicine

The health system reform debate brought into sharp focus the following fundamental query: What is the end of medicine? On the surface, this seems like an inane question. To paraphrase the French aphorism, the purpose of medicine must surely be to cure sometimes, alleviate suffering often, and comfort always. On deeper reflection, however, the question challenges many of our assumptions about the nature of doctoring and medical decision-making.

The natural upshot of the attention given to rising health care costs has been that virtually every medical intervention has come under increased scrutiny--Is this test, treatment, or procedure necessary? Is it better than doing nothing? Are the risks, costs, inconveniences, discomforts justified? Is it worth it? The drive to answer these questions, coupled with medicine's eternal striving to improve, has spawned the outcomes research and guidelines development frenzy that has taken hold over the past decade.

If the ultimate adverse outcome that can befall a patient is death, then every physician is destined to fail every patient. Former Colorado governor Richard Lamm is fond of reminding audiences that wherever he travels he finds that the mortality rate remains one per person. Yet some wags contend that Americans cling to the belief that death is an option. While it is disquieting to confront this harsh reality, the task of medicine becomes clarified; the challenge for physicians is to forestall the inevitable as long as possible while enhancing the quality of life as much as possible.

Richard G. Roberts, MD, JD

The changing nature of American medicine

Several factors have driven the questioning of medicine's basic assumptions. One factor is the changing nature of medical science. Medical innovations have blurred the boundary between life and death

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and have provided a bewildering array of treatment options. For example, it was not that many years ago when the only therapeutic choices for a patient with acute myocardial infarction included a comforting presence at the bedside, morphine for pain, and nitroglycerin and oxygen for myocardial oxygenation. Treatments today range from the mechanical (eg, ventilators) to the pharmacological (eg, thrombolytic therapies) to the electrical (eg, automatic implantable cardiac defibrillators) to the procedural (eg, angioplasties). The risk-benefit trade-off for any one innovation is not completely understood, much less the complex interaction of multiple treatment approaches. How is the physician, much less the patient, to choose?

Another factor is the changing nature of Americans. We are an increasingly diverse people with increasingly different life experiences, perspectives, and preferences. Even the most basic traditional goal of the medical encounter, preserving life for as long as possible, has been questioned by the terminally ill patient with intractable suffering or by the patient confronted by less than perfect treatment choices. Barbara McNeil, a radiologist at Harvard, several years ago asked patients with lung cancer whether they preferred radiation therapy or surgery. At the time, radiation therapy offered the best 1-year survival (because of peri-operative mortality), while surgery resulted in the best 5-year survival. Patients had very different preferences. A patient anticipating eagerly the birth of a grandchild or the wedding of a child during the next year might prefer radiation therapy; a parent of young children might opt for surgery. The value people attached to 1-year survival versus 5-year survival differed depending on their personal circumstances and their beliefs. The temptation for physicians has been to assume that the preferences of patients will be the same--that assumption may have been warranted when there were few treatment options and when a more homogeneous population shared a more common set of beliefs, but that assumption is valid no longer.

A final factor is the changing nature of medical knowledge. Medicine remains more art than science. Many practices are based more on tradition ("once a C-section, always a C-section:") or belief ("doing more is doing better") than on rigorous science. What plays well in the research laboratory or academic center protocol may not be as useful in clinical practice. Most clinicians have only the vaguest aggregate sense of what they do, much less how their patients do. A common example is sore throat. When I ask physicians how many patients they saw last year with sore throats, few are able to answer with precision nor are they easily able to find the answer. Fewer still will know how many patients had a rapid strep test or strep culture; received symptomatic therapy, penicillin or erythromycin; improved or worsened.

The future of Wisconsin medicine

The information revolution has arrived full force in medicine. Physicians need improved information tools to identify and advance best practices; patients want better information to guide their decisions; payers demand proof of quality outcomes. The State Medical Society has undertaken a bold experiment to help Wisconsin's physicians and their patients meet the challenge of this brave new world of medical science. This issue of *WMJ* describes the CESF Medical Outcomes Research Project. We believe that the project will shape the future of Wisconsin medicine and that this Wisconsin idea will influence health care for all Americans. I encourage you to read about the project--you may find some of those answers that medicine's been looking for.◆

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

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EVP report: The view from here
Managing communications in the nano-second '90s

In my address to the House of Delegates last April, I spoke at length about the dizzying pace of change in modern society. One of the most obvious areas of great change is in the technology of communications, where the revolution is so dramatic that some say it will rival the electric light bulb, the telephone, or even printing itself. The revolution is also rife with unkept promises, unrealized visions and cost-prohibitive advances. Frustration with the high-tech industry's hyperbole has led some to call the information highway the information "hype-way." The task of keeping up with the "nano-second '90s" may not be easy, but it is usually necessary, and the SMS faces the same obligations and challenges as other businesses in this regard.

Thomas L. Adams, CAE

A recent survey of large American businesses found that 53% are using the new information technology regularly--19% of the executives responding used the word "love" to sum up how they feel about their high-tech tools. Only 7% said they didn't use these tools at all.

E-mail

E-mail--a system that allows messages to be sent directly from one computer to another--is used internally by more than two thirds. One third of the executives in this poll said they use it "constantly," while another 18% said they use it "regularly." Half said that e-mail is "very effective" and only 17% questioned its effectiveness. It is the preferred method of sending instructional messages and messages requesting a response.

The SMS began using internal e-mail a couple of years ago, and it has proven a real saver of both time and paper. It allows any SMS staff member to communicate with any number of fellow staff members, from one to all, with a single key stroke. Able to keep each other so quickly and easily informed, the SMS staff's ability to work as a cohesive unit, as a team, is greatly enhanced.

V-mail

Voice mail (or v-mail) is our latest effort to be more responsive to your needs at the SMS, and more than three quarters of American businesses already use it. Nearly 40% of business executives, however, question the effectiveness of v-mail because they often get caught in a game of phone tag and because some people may hide behind the technology rather than deal directly with tough decisions or difficult conversations. More than half of those leaving v-mail messages worry that their message is never received. A good many of us object to how impersonal v-mail can be.

There are real benefits, however, to being able to speak directly and move a project forward without chasing through a message-taking process. V-mail is ideal for leaving messages that either provide or require a quick response.

At the SMS, we're trying to make this system work best for you. For instance, our v-mail is an option for you, not a demand. If the SMS staff person you wish to speak to is unavailable, you will be asked first--by a flesh and blood human--whether someone else can help you, you'd like to leave a message, or you'd like to use the v-mail. As one consultant put it, "it's a matter of putting high touch into high tech."

Looking forward

On-line services. The Internet is a global web of more than 30,000 computer networks connecting 32 million people in 70 countries, which probably sounds more impressive than it really is. For most of us, the information superhighway is still an information cowpath. Only 12% of American businesses with more

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than 100 employees report "constant" use of Internet, and when we asked 7,700 SMS members whether they would make at least weekly use of a computer bulletin board service, only 178 answered affirmatively. In fact, only about half of those responding to the SMS survey have the necessary equipment to make use of on-line services. In the business poll, three quarters said they thought working in cyberspace is either very or somewhat effective, despite the low level of current use. It seems that this part of the communications revolution just hasn't come to fruition yet.

The SMS has the ability to send and receive information in cyberspace today, but its full use and full value remains somewhere in the future.

Video teleconferences. While only 18% of the large American businesses in the survey now use video teleconferencing, another 48% say they are likely to try it or install it within the next 2 years. Those who use this method of holding meetings are certain of its value: 75% say it reduces travel time and expense, 59% say it's a great communications tool, and almost 50% say it increases productivity.

Shell Oil now uses a dozen teleconference sites, including one on an off-shore rig in the Gulf of Mexico, with voice-activated cameras and intends to enhance this network until it includes every one of its facilities. Even Kinko's, where we're used to making copies and sending fax messages, has set up more than 100 teleconference sites in 77 cities. Some large companies are experimenting with cameras mounted on top of computers and predicting it will soon change the way business is conducted.

Video teleconferencing is the part of the revolution that holds the most promise for the SMS. Its application to the work of the Society is clear and direct, but both cost and availability remain barriers. Indeed, the business survey found that 70% said this technology is currently cost-prohibitive and 50% said it is not widespread enough to make it worthwhile. Both of these barriers are likely to fall in the near future. When physicians are able to participate in SMS committee meetings without taking a day or more from their practices to travel to Madison, time will be saved, money will be saved, productivity will rise, and member participation in SMS activities will be enhanced.

Communicating

Of course, the mere conveyance of information is not the same thing as communication, and communication is the soul of any professional association. Every day, we see people teetering on the brink of information overload. We are becoming besieged by so much data, so many requests, solicitations, judgments, and demands--all insisting on immediate responses--that we are hurdling toward darkness at the speed of light. Peter Lewis, of the New York *Times*, reported that a year ago he received 20 e-mail messages a day--he now gets 100. Too much information too fast creates chaos, not communication.

The gathering and distilling of information on its members' behalf has always been one of the roles of the SMS, but as we move toward the next century it will have to become our strength. The SMS will be your best advocate in the revolution, as it manages the flood of information and transforms it into genuine communication fit for human consumption.

And lest you worry that your society will be reduced to a disembodied voice at the far end of a telephone line, let me reassure you that the human qualities of your organization will not be lost. We know that our words are only 7% of how we communicate, that tone of voice is 38%,and that body language, eye contact, facial expression and gestures constitute 55%. E-mail, v-mail, and video conferences may augment human contact, but it can never replace it, no matter how sophisticated the technology becomes.

Of course, the flip side of communications--perhaps the more important side--is listening. This is particularly true among associations, and you can count on it being the hallmark of your State Medical Society. The high-tech wonders are only tools to help us help you.

Your goals and your frustrations, your dreams and your fears: These will continue to be the driving force of the SMS. And regardless of how the world changes, regardless of whether you send us your message with a handshake or an electric impulse, the SMS staff will be here to listen and respond. It is our purpose as much as it is our promise.❖

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Editorials
Arrogant faculty

THE RESIGNATION OF Lawrence Martin from the position of dean of the University of Wisconsin Medical School signals the lack of appreciation for medical school's mission by at least some of the faculty. The need for more primary care physicians becomes more evident every day--certainly, the production of more specialists, especially surgical specialists, is *not* called for--and I believe it was Dean Martin's intent to address this need that created his trouble with some of the faculty. The failure to appreciate the medical school's new mission seems to stem from poorly ordered priorities.

First, there are those who may put the pursuit of money ahead of all else. From my personal experience, gained from attending the dean's first long-range planning session with a few of the players in the faculty, I suspect the dean's plans included invading the supersanctum of faculty entrepreneurs who resist any tampering with the current economic system of the medical school because it is greatly to their personal financial advantage. Greed does not exist solely in professional sports.

Second, there are those who may not put the medical needs of US citizens very high on their priority list. Is it a coincidence that foreign nationals were among the leaders of the revolt against the dean and his efforts to help the medical school respond to the demonstrated, desperate need of the people of Wisconsin--and, for that matter, the citizens of this country--for more primary care physicians?

In talking about the implications of what happened at the UW Medical School, we could go on at length about avarice, about the public image of the medical profession, about personal and professional ethics, about justice, even about patriotism. But the primary issue has to be that medicine *must* respond to the needs of the people it serves. If we do not, we fail on moral grounds and we risk eventual failures in professional, public relations, political, and pecuniary endeavors.

Dean Martin was trying to help us respond to our patients' needs, but it seems other, less worthy, priorities may have gotten in the way. That's not just a shame, that's dangerous.

--Richard D. Sautter, MD
medical editor◆

Letters
Kudos for Roberts

TO THE EDITOR: Congratulations on Dr Roberts' fine editorial "Ciphering the new alphabet," president's page, *Wisconsin Medical Journal*, November 1994. He did an excellent job of covering a timely and important subject. It is about time that organized medicine stops giving into governmental bureaucrats, insurance companies, employers and the press among others which continually attempt to direct the practice of medicine. It was nice to hear someone stand up for a change and point out the education and responsibility of the physician as well as his obligations to look out for his or her patients. If you don't have to be a physician to practice medicine, we have all spent a lot of time, energy and money to achieve excellence in our healing professions.

Again, congratulations on an excellent article.

—John W. Utrie, MD
Green Bay◆

Soundings

The Magical Medical Mind

Far from home and stranded
In a foreign land of wizards
The game we play today began
But it had no clear beginning

The students huddled, hoping
To survive and willing to mumble
Numbers and black magic
As they were instructed to do
By the scribblings
Of a demented Osler

The residents, some like sharks
others like wild horses
Patrolled their domains
Seeking control over their worlds
With a foot in heaven
And another in hell

The attendings, cloaked in power
Remained invisible; secret oaths
Long since uttered held their power
Very effectively, spells unbreakable

And magicians we are!
On a great white horse, like a missile,
I am traveling this gauntlet
And within, my own secret powers
Carry me fast and furiously
To a kingdom of safety
To tend to a new flock
Of my own followers

--Reuben Lubka, MD
Wauwatosa◆

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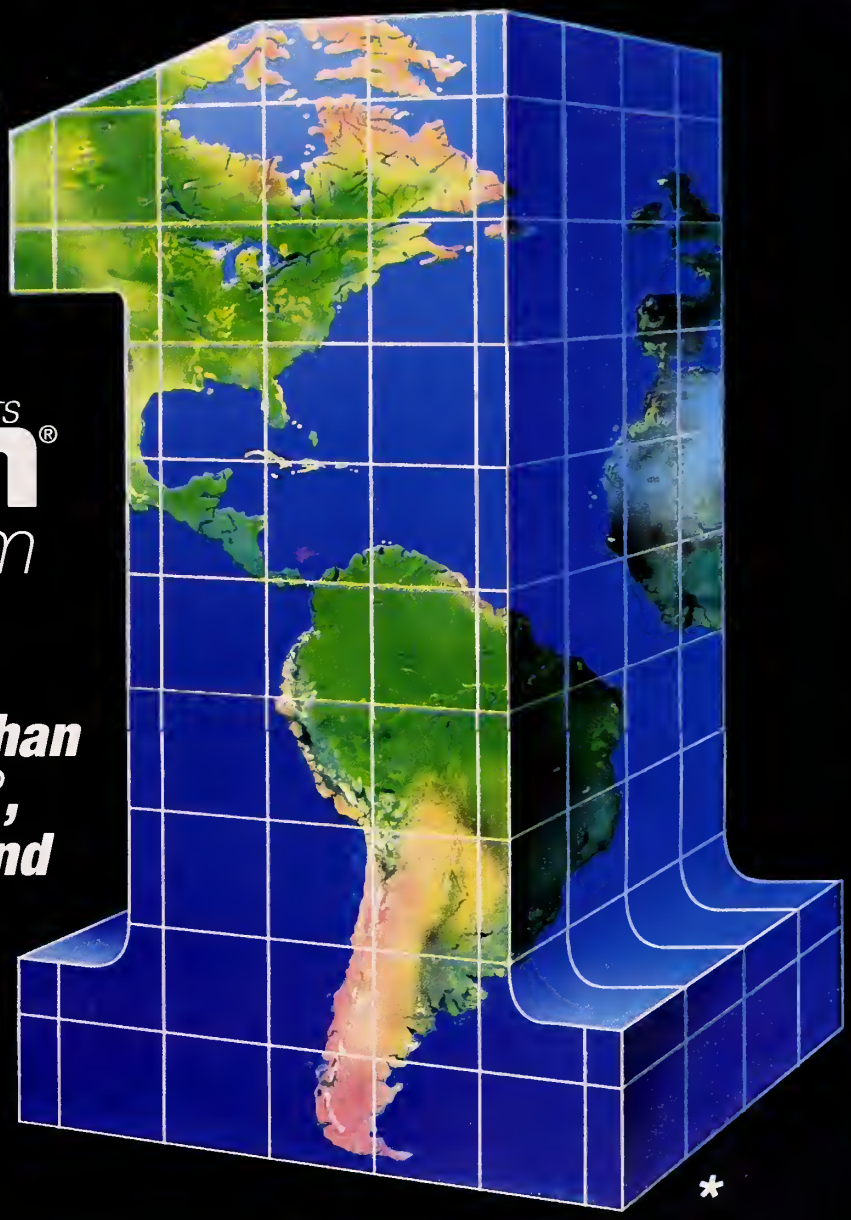

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WARNINGS

Gastrointestinal Effects

Peptic ulceration and gastrointestinal bleeding have been reported in patients receiving diclofenac. Physicians and patients should therefore remain alert for ulceration and bleeding in patients treated chronically with diclofenac even in the absence of previous G.I. tract symptoms. It is recommended that patients be maintained on the lowest dose of diclofenac possible, consistent with achieving a satisfactory therapeutic response.

Risk of G.I. Ulcerations, Bleeding, and Perforation with NSAID Therapy: Serious gastrointestinal toxicity such as bleeding, ulceration, and perforation can occur at any time, with or without warning symptoms, in patients treated chronically with NSAID therapy. Although minor upper gastrointestinal problems, such as dyspepsia, are common, usually developing early in therapy, physicians should remain alert for ulceration and bleeding in patients treated chronically with NSAIDs even in the absence of previous G.I. tract symptoms. In patients observed in clinical trials of several months to 2 years' duration, symptomatic upper G.I. ulcers, gross bleeding, or perforation appear to occur in approximately 1% of patients for 3-6 months, and in about 2%-4% of patients treated for 1 year. Physicians should inform patients about the signs and/or symptoms of serious G.I. toxicity and what steps to take if they occur.

Studies to date have not identified any subset of patients not at risk of developing peptic ulceration and bleeding. Except for a prior history of serious G.I. events and other risk factors known to be associated with peptic ulcer disease, such as alcoholism, smoking, etc., no risk factors (e.g., age, sex) have been associated with increased risk. Elderly or debilitated patients seem to tolerate ulceration or bleeding less well than other individuals, and most spontaneous reports of fatal G.I. events are in this population. Studies to date are inconclusive concerning the relative risk of various NSAIDs in causing such reactions. High doses of any NSAID probably carry a greater risk of these reactions, although controlled clinical trials showing this do not exist in most cases. In considering the use of relatively large doses (within the recommended dosage range), sufficient benefit should be anticipated to offset the potential increased risk of G.I. toxicity.

Hepatic Effects

As with other NSAIDs, elevations of one or more liver tests may occur during diclofenac therapy. These laboratory abnormalities may progress, may remain unchanged, or may be transient with continued therapy. Borderline elevations (i.e., less than 3 times the ULN [= the Upper Limit of the Normal range]), or greater elevations of transaminases occurred in about 15% of diclofenac-treated patients. Of the hepatic enzymes, ALT (SGPT) is the one recommended for the monitoring of liver injury.

In clinical trials, meaningful elevations (i.e., more than 3 times the ULN) of AST (SGOT) (ALT was not measured in all studies) occurred in about 2% of approximately 5700 patients at some time during Voltaren treatment. In a large, open, controlled trial, meaningful elevations of ALT and/or AST occurred in about 4% of 3700 patients treated for 2-6 months, including marked elevations (i.e., more than 8 times the ULN) in about 1% of the 3700 patients. In that open-label study, a higher incidence of borderline (less than 3 times the ULN), moderate (3-8 times the ULN), and marked (> 8 times the ULN) elevations of ALT or AST was observed in patients receiving diclofenac when compared to other NSAIDs. Transaminase elevations were seen more frequently in patients with osteoarthritis than in those with rheumatoid arthritis (see ADVERSE REACTIONS).

In addition to the enzyme elevations seen in clinical trials, rare cases of severe hepatic reactions, including jaundice and fatal fulminant hepatitis, have been reported.

Physicians should measure transaminases periodically in patients receiving long-term therapy with diclofenac, because severe hepatotoxicity may develop without a prodrome of distinguishing symptoms. The optimum times for making the first and subsequent transaminase measurements are not known. In the largest U.S. trial (open-label) that involved 3700 patients monitored first at 8 weeks and 1200 patients monitored again at 24 weeks, almost all meaningful elevations in transaminases were detected before patients became symptomatic. In 42 of the 51 patients in all trials who developed marked transaminase elevations, abnormal tests occurred during the first 2 months of therapy with diclofenac. Based on this experience, if diclofenac is used chronically, the first transaminase measurement should be made no later than 8 weeks after the start of diclofenac treatment. As with other NSAIDs, if abnormal liver tests persist or worsen, if clinical signs and/or symptoms consistent with liver disease develop, or if systemic manifestations occur (e.g., eosinophilia, rash, etc.), diclofenac should be discontinued.

To minimize the possibility that hepatic injury will become severe between transaminase measurements, physicians should inform patients of the warning signs and symptoms of hepatotoxicity (e.g., nausea, fatigue, lethargy, pruritus, jaundice, right upper quadrant tenderness, and "flu-like" symptoms), and the appropriate action patients should take if these signs and symptoms appear.

PRECAUTIONS

General

Allergic Reactions: As with other NSAIDs, allergic reactions including anaphylaxis have been reported with diclofenac. Specific allergic manifestations consisting of swelling of eyelids, lips, pharynx, and larynx, urticaria, asthma, and bronchospasm, sometimes with a concomitant fall in blood pressure (severe at times) have been observed in clinical trials and/or the marketing experience with diclofenac. Anaphylaxis has rarely been reported from foreign sources; in U.S. clinical trials with diclofenac in over 6000 patients, 1 case of anaphylaxis was reported. In controlled clinical trials, allergic reactions have been observed at an incidence of 0.5%. These reactions can occur without prior exposure to the drug.

Fluid Retention and Edema: Fluid retention and edema have been observed in some patients taking diclofenac. Therefore, as with other NSAIDs, diclofenac should be used with caution in patients with a history of cardiac decompensation, hypertension, or other conditions predisposing to fluid retention.

Renal Effects: As a class, NSAIDs have been associated with renal papillary necrosis and other abnormal renal pathology in long-term administration to animals. In oral diclofenac studies in animals, some evidence of renal toxicity was noted. Isolated incidents of papillary necrosis were observed in a few animals at high doses (20-120 mg/kg) in several baboon subacute studies. In patients treated with diclofenac, rare cases of interstitial nephritis and papillary necrosis have been reported (see ADVERSE REACTIONS).

A second form of renal toxicity, generally associated with NSAIDs, is seen in patients with conditions leading to a reduction in renal blood flow or blood volume, where renal prostaglandins have a supportive role in the maintenance of renal perfusion. In these patients, administration of an NSAID results in a dose-dependent decrease in prostaglandin synthesis and, secondarily, in a reduction of renal blood flow, which may precipitate overt renal failure. Patients at greatest risk of this reaction are those with impaired renal function, heart failure, liver dysfunction, those taking diuretics, and the elderly. Discontinuation of NSAID therapy is typically followed by recovery to the pretreatment state.

Cases of significant renal failure in patients receiving diclofenac have been reported from marketing experience, but were not observed in over 4000 patients in clinical trials during which serum creatinine and BUN values were followed serially. There were only 11 patients (0.3%) whose serum creatinine and concurrent serum BUN values were greater than 2.0 mg/dL and 40 mg/dL, respectively, while on diclofenac (mean rise in the 11 patients' creatinine 2.3 mg/dL and BUN 28.4 mg/dL).

Since diclofenac metabolites are eliminated primarily by the kidneys, patients with significantly impaired renal function should be more closely monitored than subjects with normal renal function.

Porphyria: The use of diclofenac in patients with hepatic porphyria should be avoided. To date, 1 patient has been described in whom diclofenac probably triggered a clinical attack of porphyria. The postulated mechanism, demonstrated in rats, for causing such attacks by diclofenac, as well as some other NSAIDs, is through stimulation of the porphyrin precursor delta-aminolevulinic acid (ALA).

Information for Patients

Diclofenac, like other drugs of its class, is not free of side effects. The side effects of these drugs can cause discomfort and, rarely, there are more serious side effects, such as gastrointestinal bleeding, and more rarely, liver toxicity (see WARNINGS, Hepatic Effects), which may result in hospitalization and even fatal outcomes.

NSAIDs are often essential agents in the management of arthritis and have a major role in the management of pain, but they also may be commonly employed for conditions that are less serious.

Physicians may wish to discuss with their patients the potential risks (see WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS) and likely benefits of NSAID treatment, particularly when the drugs are used for less serious conditions where treatment without NSAIDs may represent an acceptable alternative to both the patient and physician.

Laboratory Tests

Because serious G.I. tract ulceration and bleeding can occur without warning symptoms, physicians should follow chronically treated patients for the signs and symptoms of ulceration and bleeding and should inform them of the importance of this follow-up (see WARNINGS, *Risk of G.I. Ulcerations, Bleeding, and Perforation with NSAID Therapy*). If diclofenac is used chronically, patients should also be instructed to report any signs and symptoms that might be due to hepatotoxicity of diclofenac; these symptoms may become evident between visits when periodic liver laboratory tests are performed (see WARNINGS, Hepatic Effects).

Drug Interactions

Aspirin: Concomitant administration of diclofenac and aspirin is not recommended because diclofenac is displaced from its binding sites during the concomitant administration of aspirin, resulting in lower plasma concentrations, peak plasma levels, and AUC values.

Anticoagulants: While studies have not shown diclofenac to interact with anticoagulants of the warfarin type, caution should be exercised, nonetheless, since interactions have been seen with other NSAIDs. Because prostaglandins play an important role in hemostasis, and NSAIDs affect platelet function as well, concurrent therapy with all NSAIDs, including diclofenac, and warfarin requires close monitoring of patients to be certain that no change in their anticoagulant dosage is required.

Digoxin, Methotrexate, Cyclosporine: Diclofenac, like other NSAIDs, may affect renal prostaglandins and increase the toxicity of certain drugs. Ingestion of diclofenac may increase serum concentrations of digoxin and methotrexate and increase cyclosporine's nephrotoxicity. Patients who begin taking diclofenac or who increase their diclofenac dose or any other NSAID while taking digoxin, methotrexate, or cyclosporine may develop toxicity characteristics for these drugs. They should be observed closely, particularly if renal function is impaired. In the case of digoxin, serum levels should be monitored.

Lithium: Diclofenac decreases lithium renal clearance and increases lithium plasma levels. In patients taking diclofenac and lithium concomitantly, lithium toxicity may develop.

Oral Hypoglycemics: Diclofenac does not alter glucose metabolism in normal subjects nor does it alter the effects of oral hypoglycemic agents. There are rare reports, however, from marketing experiences of changes in effects of insulin or oral hypoglycemic agents in the presence of diclofenac that necessitated changes in the doses of such agents. Both hypo- and hyperglycemic effects have been reported. A direct causal relationship has not been established, but physicians should consider the possibility that diclofenac may alter a diabetic patient's response to insulin or oral hypoglycemic agents.

Diuretics: Diclofenac and other NSAIDs can inhibit the activity of diuretics. Concomitant treatment with potassium-sparing diuretics may be associated with increased serum potassium levels.

Other Drugs: In small groups of patients (7-10/interaction study), the concomitant administration of azathioprine, gold, chloroquine, D-penicillamine, prednisolone, doxycycline, or digitoxin did not significantly affect the peak levels and AUC values of diclofenac.

Protein Binding

In vitro, diclofenac interferes minimally or not at all with the protein binding of salicylic acid (20% decrease in binding), tolbutamide, prednisolone (10% decrease in binding), or warfarin. Benzylpenicillin, ampicillin, oxacillin, chlortetracycline, doxycycline, cephalothin, erythromycin, and sulfamethoxazole have no influence in vitro on the protein binding of diclofenac in human serum.

Drug/Laboratory Test Interactions

Effect on Blood Coagulation: Diclofenac increases platelet aggregation time but does not affect bleeding time, plasma thrombin clotting time, plasma fibrinogen, or factors V and VII to XII. Statistically significant changes in prothrombin and partial thromboplastin times have been reported in normal volunteers. The mean changes were observed to be less than 1 second in both instances, however, and are unlikely to be clinically important. Diclofenac is a prostaglandin synthetase inhibitor, however, and all drugs that inhibit prostaglandin synthesis interfere with platelet function to some degree, therefore, patients who may be adversely affected by such an action should be carefully observed.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in rats given diclofenac sodium up to 2 mg/kg/day or (12 mg/m²/day approximately the human dose) have revealed no significant increases in tumor incidence. There was a slight increase in benign mammary fibroadenomas in mid-dose-treated (0.5 mg/kg/day or 3 mg/m²/day) female rats (high-dose females had excessive mortality), but the increase was not significant for this common rat tumor. A 2-year carcinogenicity study conducted in mice employing diclofenac sodium at doses up to 0.3 mg/kg/day (0.9 mg/m²/day) in males and 1 mg/kg/day (3 mg/m²/day) in females did not reveal any oncogenic potential. Diclofenac sodium did not show mutagenic activity in in vitro point mutation assays in mammalian (mouse lymphoma) and microbial (yeast, Ames) test systems and was nonmutagenic in several mammalian in vitro and in vivo tests, including dominant lethal and male germinal epithelial chromosomal studies in mice, and nucleus anomaly and chromosomal aberration studies in Chinese hamsters. Diclofenac sodium administered to male and female rats at 4 mg/kg/day (24 mg/m²/day) did not affect fertility.

Teratogenic Effects

There are no adequate and well-controlled studies in pregnant women. Diclofenac should be used during pregnancy only if the benefits to the mother justify the potential risk to the fetus.

Pregnancy Category B: Reproduction studies have been performed in mice given diclofenac sodium (up to 20 mg/kg/day or 60 mg/m²/day) and in rats and rabbits given diclofenac sodium (up to 10 mg/kg/day or 60 mg/m²/day for rats, and 80 mg/m²/day for rabbits), and have revealed no evidence of teratogenicity despite the induction of maternal toxicity and fetal toxicity. In rats, maternally toxic doses were associated with dystocia, prolonged gestation, reduced fetal weights and growth, and reduced fetal survival. Diclofenac has been shown to cross the placental barrier in mice and rats.

Labor and Delivery

The effects of diclofenac on labor and delivery in pregnant women are unknown. Because of the known effects of prostaglandin-inhibiting drugs on the fetal cardiovascular system (closure of ductus arteriosus), use of diclofenac during late pregnancy should be avoided and, as with other nonsteroidal anti-inflammatory drugs, it is possible that diclofenac may inhibit uterine contraction.

Nursing Mothers

Diclofenac has been found in the milk of nursing mothers. As with other drugs that are excreted in milk, diclofenac is not recommended for use in nursing women.

Pediatric Use

Safety and effectiveness of diclofenac in children have not been established.

Geriatric Use

Of the more than 6000 patients treated with diclofenac in U.S. trials, 31% were older than 65 years of age. No overall difference was observed between efficacy, adverse event or pharmacokinetic profiles of older and younger patients. As with any NSAID, the elderly are likely to tolerate adverse reactions less well than younger patients.

ADVERSE REACTIONS

Adverse reaction information is derived from blinded, controlled and open-label clinical trials, as well as worldwide marketing experience. In the description below, rates of more common events represent clinical study results, rarer events are derived principally from marketing experience and publications, and accurate rate estimates are generally not possible.

In a 6-month, double-blind trial comparing Voltaren Delayed-Release Tablets (N=197) vs Cataflam Immediate-Release Tablets (N=196) vs ibuprofen (N=197), adverse reactions were similar in nature and frequency. In 718 patients treated for shorter periods, i.e., 2 weeks or less, with *Cataflam Immediate-Release Tablets*, adverse reactions were reported one-half to one-tenth as frequently as by patients treated for longer periods.

The incidence of common adverse reactions (greater than 1%) is based upon controlled clinical trials in 1543 patients treated up to 13 weeks with *Voltaren Delayed-Release Tablets*. By far the most common adverse effects were gastrointestinal symptoms, most of them minor, occurring in about 20%, and leading to discontinuation in about 3%, of patients. Peptic ulcer or G.I. bleeding occurred in clinical trials in 0.6% (95% confidence interval: 0.2% to 1%) of approximately 1800 patients during their first 3 months of diclofenac treatment and in 1.6% (95% confidence interval: 0.8% to 2.4%) of approximately 800 patients followed for 1 year.

Gastrointestinal symptoms were followed in frequency by central nervous system side effects such as headache (7%) and dizziness (3%).

Meaningful (exceeding 3 times the Upper Limit of Normal) elevations of ALT (SGPT) or AST (SGOT) occurred at an overall rate of approximately 2% during the first 2 months of Voltaren treatment. Unlike aspirin-related elevations, which occur more frequently in patients with rheumatoid arthritis, these elevations were more frequently observed in patients with osteoarthritis (2.6%) than in patients with rheumatoid arthritis (0.7%). Marked elevations (exceeding 8 times the ULN) were seen in 1% of patients treated for 2-6 months (see WARNINGS, Hepatic Effects).

The following adverse reactions were reported in patients treated with diclofenac:

Incidence Greater Than 1% - Causal Relationship Probable: (All derived from clinical trials.)

Body as a Whole: Abdominal pain or cramps,* headache,* fluid retention, abdominal distention.

Digestive: Diarrhea,* indigestion,* nausea,* constipation,* flatulence, liver test abnormalities,* PUB, i.e., peptic ulcer, with or without bleeding and/or perforation, or bleeding without ulcer (see above and also WARNINGS).

Nervous System: Dizziness.

Skin and Appendages: Rash, pruritus.

Special Senses: Tinnitus.

*Incidence, 3% to 9% (incidence of unmarked reactions is 1%-3%).

Incidence Less Than 1% - Causal Relationship Probable: (The following reactions have been reported in patients taking diclofenac under circumstances that do not permit a clear attribution of the reaction to diclofenac. These reactions are being included as alerting information to physicians. Adverse reactions reported only in worldwide *marketing experience* or in the literature, not seen in clinical trials, are considered rare and are italicized.)

Body as a Whole: Malaise, swelling of lips and tongue, photosensitivity, *anaphylaxis*, anaphylactoid reactions.

Cardiovascular: Hypertension, congestive heart failure.

Digestive: Vomiting, jaundice, melena, aphthous stomatitis, dry mouth and mucous membranes, bloody diarrhea, hepatitis, *hepatic necrosis*, appetite change, pancreatitis with or without concomitant hepatitis, *colitis*.

Hemic and Lymphatic: Hemoglobin decrease, leukopenia, thrombocytopenia, *hemolytic anemia, aplastic anemia, agranulocytosis*, purpura, *allergic purpura*.

Metabolic and Nutritional Disorders: Azotemia.

Nervous System: Insomnia, drowsiness, depression, diplopia, anxiety, irritability, *aseptic meningitis*.

Respiratory: Epistaxis, asthma, laryngeal edema.

Skin and Appendages: Alopecia, urticaria, eczema, dermatitis, *bullous eruption, erythema multiforme major*, angioedema, *Stevens-Johnson syndrome*.

Special Senses: Blurred vision, taste disorder, reversible hearing loss, scotoma.

Urogenital: *Nephrotic syndrome*, proteinuria, *oliguria, interstitial nephritis, papillary necrosis, acute renal failure*.

Incidence Less Than 1% - Causal Relationship Unknown: (Adverse reactions reported only in worldwide marketing experience or in the literature, not seen in clinical trials, are considered rare and are italicized.)

Body as a Whole: Chest pain.

Cardiovascular: Palpitations, *flushing*, tachycardia, premature ventricular contractions, myocardial infarction.

Digestive: Esophageal lesions.

Hemic and Lymphatic: *Bruising*.

Metabolic and Nutritional Disorders: Hypoglycemia, *weight loss*.

Nervous System: Paresthesia, memory disturbance, nightmares, tremor, tic, *abnormal coordination*, convulsions, *disorientation, psychotic reaction*.

Respiratory: Dyspnea, hyperventilation, edema of pharynx.

Skin and Appendages: Excess perspiration, *exfoliative dermatitis*.

Special Senses: Vitreous floaters, night blindness, amblyopia.

Urogenital: Urinary frequency, nocturia, hematuria, impotence, vaginal bleeding.

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Wisconsin's future requirements for generalist physicians: Is the state's training capacity sufficient?

Nancy Cross Dunham, PhD; David A. Kindig, MD, PhD; and Donald Libby, PhD, Madison

The need for expansion of generalist residency training programs in Wisconsin is considered, using population-based considerations and projection models that estimate the future statewide supply of and requirements for generalist physicians. In 1990, Wisconsin's generalist physician-to-population ratio was relatively low, at 59 per 100,000 population. The supply of generalists per 100,000 population was also highly variable across broad geographic areas of the state, with 16 of Wisconsin's 25 Health Service Areas having ratios which fell below 59 per 100,000 population. These patterns may not automatically translate into the need for expansion of Wisconsin's generalist residency training capacity, however. The projection model indicates that, even with no expansion of graduate medical education capacity for generalist physicians, the statewide supply could grow to more than 70 generalists per 100,000 population by the year 2015. Expansion of the state's generalist training capacity would also not guarantee that any additional generalist physicians trained in the state would actually locate in areas where they would be most needed. Policy efforts to provide incentives for generalist physicians to locate in under-served areas should continue to be supported. *Wis Med J.1995:94(1):13-19.*

Over the last few years, national health policy-makers have become increasingly concerned with the discrepancies in the numbers of qeneralist and specialist physicians practicing in the United States. Reflecting this concern, the Council on Graduate Medical Education (COGME) has recently proposed a public policy goal that at least 50% of US medical school graduates should complete a 3-year residency and enter practice in the generalist disciplines of family practice, general internal medicine, and general pediatrics.[1]

In 1993, the Wisconsin legislature called on the state's two medical schools to submit a report describing their primary care education and training programs. In response to this legislative request, a report was prepared which stated the schools' intentions to pursue a goal of having 50% of their graduates enter practice in family medicine, general internal medicine, and general pediatrics by the year 2000.[2] As one way to meet this goal, the report recommended, among other things, that the two schools explore the need for additional generalist residency training opportunities in the state.

In this paper, we consider the need for the expansion of generalist residency training programs in Wisconsin. An important question to be addressed in this regard is: What is the evidence that the output from Wisconsin's residency programs is or is not sufficient to provide for future state generalist physician requirements?

Methods

A focus of this article is the projection of future supply and requirements for generalist physicians in Wisconsin. For the purposes of determining generalist physician supply and requirements for the state, generalist physicians will be defined as non-federal MDs and DOs, minus residents and fellows, in the specialties of general practice, family practice, general internal medicine, and general pediatrics.

Modeling generalist physician requirements. Kindig has recently pointed out that stating physician workforce goals in terms of percentages (eg, having 50% of graduates enter generalist practice) does not take into account population need or demand.[3] From a public policy perspective, physician-to-population ratios (ie, the number of physicians

Table 1. - Practicing generalist physicians in Wisconsin by health service area, 1990, and change in number needed to match three standards of generalist physician requirements.

HSA identifier number*	Total Generalists†	Generalists/ 100K pop.	Change in number of generalists required 59/100K pop.	69/100K pop.	80/100K pop.
278	125	46	34	61	90
280	949	66	-104	39	197
282	178	67	-20	6	36
284	50	77	-12	-5	2
286	27	77	-6	-3	1
289	19	45	6	10	14
290	132	71	-23	-4	16
298	124	64	-9	10	31
301	412	74	-82	-26	35
306	153	44	51	85	123
314	12	44	4	7	10
315	24	58	3	8	13
326	98	53	12	30	51
344	108	58	2	21	42
350	9	56	1	2	4
355	87	40	42	64	88
357	37	62	-1	5	11
370	41	49	8	16	25
374	37	66	-4	2	8
379	34	56	2	8	15
382	126	42	53	83	116
387	68	48	16	31	46
391	10	27	12	16	20
399	7	41	3	5	7
400	27	44	9	15	22
Total Wisconsin	2,894	59			
Net change			-3	486	1,023
Gross change			258	524	1,023

*HSAs identified by Medicare patient travel for routine medical care. Identifier numbers assigned by National Center for Health Statistics.
†Total generalists = all practicing MDs and DOs in family practice, general internal medicine and general pediatrics (minus residents and fellows).

per 100,000 persons in an area) are likely to be more useful than generalist: specialist proportions in evaluating the adequacy of physician supply.

In this paper, three levels of future generalist physician requirements are considered: 59, 69, and 80 per 100,000 population. The first two levels (59 and 69 physicians per 100,000 population) come from recent managed care studies of Weiner.[4] The estimates developed by Weiner are the most careful work to date on the likely effect of managed care organizations on physician requirements in the future, taking into account the different proportions of generalists and specialties used by fee-for-service and managed care plans, and using projections of future managed care market penetration.

Weiner's projections anticipate considerable changes in the US health care delivery system. He projects, for example, that between 40% and 65% of Americans will be receiving care from managed care organizations or networks in the near future (compared to 25% currently), and all citizens will be covered by some type of health insurance.

Weiner's model also assumes a fairly high level of efficiency in the organization and delivery of services by these health care organizations. His requirements projections result, therefore, in fairly low requirements for generalist physicians per 100,000 population.

Recent work done by the Bureau of Health Professions, US Public Health Service (BHPr) provides the upper end of the range of generalist physician requirements which we use in this report (ie, 80 per 100,000 population).[5] The BHPr model used assumptions about the growth in managed care enrollment which were similar to those of Weiner. The BHPr, however, was more conservative than Weiner with regard to the efficiency of managed care plans and, therefore, projects a higher level of requirements for generalist physicians.

Modeling generalist physician supply. One objective of this report is to present the results of a projection model which estimates future increases to Wisconsin's supply of generalist physicians over the next two decades, specifically, for the years 2005 and 2015. In developing this model, it was necessary to make several simplifying assumptions regarding additions to, and attrition from, the 1990 supply.

The first of these simplifying assumptions for the supply model is that past patterns of retention for physicians who begin their generalist residency training in the state will remain stable over the projection period. Second, the projection

model does not specifically account for in- and out-migration rates for Wisconsin physicians over the next 20 years. More details on the assumptions and methods used in developing this projection model are provided in a recently released report of the Wisconsin Network for Health Policy Research.[6]

Results

Wisconsin's 1990 supply of generalist physicians. In 1990, Wisconsin had a total of 7,470 non-federal patient care physicians (MDs and DOs, excluding residents and clinical fellows). A total of 2,894 of these physicians were generalists (1,556 were general or family practitioners, 930 were general internists, and 408 were general pediatricians).[7] Thus, 39% of the state's supply of physicians were generalists in 1990. The statewide patient care generalist physician-to-population ratio was 59 per 100,000, a level of supply which exactly matches Weiner's lower bound of requirements estimates for the year 2000.

Table 1 presents data on the number of practicing generalist physicians, and the resulting ratios of generalist physicians per 100,000 population across Health Service Areas (HSAs) in Wisconsin. In addition, Figure 1 presents a map which more clearly highlights differences in generalist physician-to-populations across HSAs in the state.

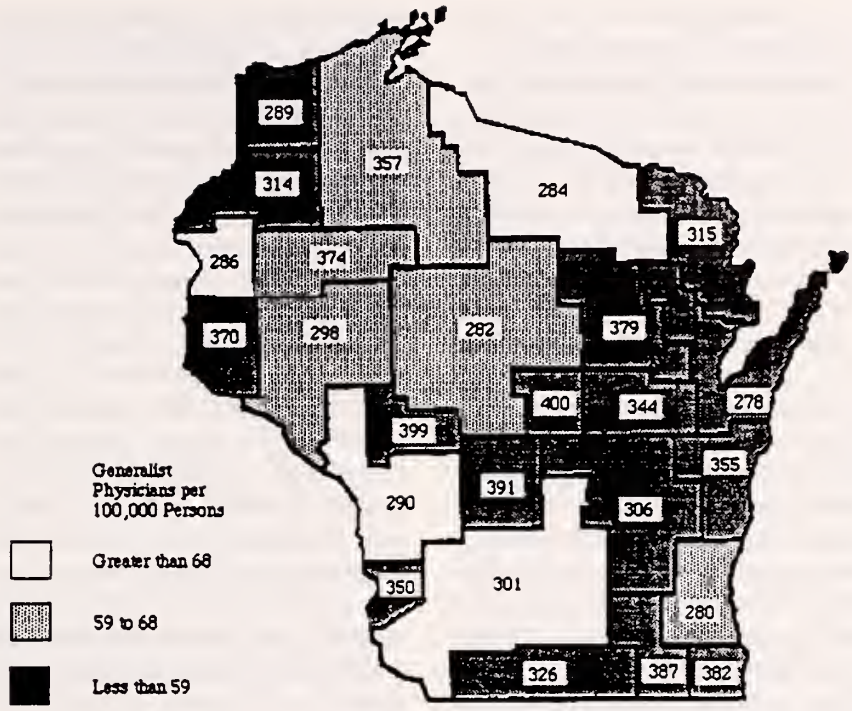

Fig 1. - Relative availability of generalist physicians per 100,000 persons in Wisconsin HSAs, 1990. Adapted from Fig III in Health Service Areas for the United States, National Center for Health Statistics, Vital and Health Statistics Series 2, Number 112, 1991.

The National Center for Health Statistics (NCHS) has defined HSAs as areas of one or more counties that are relatively self-contained with regard to where patients travel to receive routine hospital care. The NCHS has identified approximately 800 HSAs for the nation as a whole, based on the analysis of Medicare discharge data. Each individual HSA has been assigned a unique identifier by the NCHS.[8]

Both Table 1 and Figure 1 show that there is significant variability in the supply of generalist physicians across the state. For example, 16 of Wisconsin's 25 HSAs had generalist physician-to-population ratios in 1990 which were below 59 per 100,000 population, the lower bound of requirements being considered here. Five HSAs had generalist physician-to-population ratios which were between 59 and 69 per 100,000 population. Four HSAs had ratios above 69 per 100,000 population (only 2 of which, at 77 per 100,000 population, approached BHPr's upper bound of requirements projection of 80 per 100,000).

Table 1 also presents data which indicate the change in the number of generalist physicians that would have been needed in 1990 (ie, increases or decreases from the existing supply) for each HSA to have matched the low, medium, and high requirements estimates we are considering. At the bottom of Table 1, we summarize this information and show:

- the net additions needed to meet the three standards of generalist physician availability; that is, if physicians could be moved from areas having generalist physician-to-populations ratios exceeding the requirements estimate to those

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whose supplies were below the requirements estimate; and

- the gross additions needed; that is, the sum of all increases in supply needed to bring those counties that were below the requirements estimate up to match requirements, without making any changes to areas whose physician-to-population ratios were above the requirements estimate.

These data suggest that, in 1990, Wisconsin would have had a sufficient supply of generalist physicians to meet Weiner's requirements standard of 59 per 100,000 population, if those generalists had been distributed across the state more evenly. To bring those HSAs that had fewer than 59 generalists per 100,000 population up to meet that ratio, without changing the supply in the other HSAs (gross change), the state would have required an additional 258 generalist physicians. The net and gross changes needed to meet the higher requirements estimate of 69 per 100,000 population are 486 and 524 generalist physicians respectively. Because none of the HSAs exceeded the higher ratio of 80 generalists per 100,000 population, the net and gross numbers needed to bring all of the HSAs up to this higher requirements estimate are equal: 1,023 generalist physicians.

Projecting Wisconsin's future generalist physician supply. In the 1994 National Residency Matching Program, Wisconsin had 189 first year (PGY-1) generalist residency positions (82 in family medicine, 66 in general internal medicine, and 41 in pediatrics). Recent patterns of retention of generalist physicians from these programs suggest that the state's qeneralist residency programs will produce 138 new generalist physicians annually from this cohort of residents. Of these, approximately 65% to 75% are anticipated to locate their practices in Wisconsin, meaning that between 91 and 104 of these 138 generalist physicians will choose to locate their practices in Wisconsin.[9] For our projection model, we use the approximate mid-point of this range—100—to project the annual output of generalist physicians to Wisconsin from the state's residency programs.

Table 2 presents the summary results of our generalist physician supply projection model for the years 2005 and 2025. The model projects that, given the state's existing graduate medical education (GME) capacity, and assuming present retention rates of generalist physicians from the state's GME programs, there will be approximately 1,500 total additions to the state's pool of generalist physicians from 1990 through the year 2005, and 2,500 additions through the year 2015 (ie, an average of 100 per year).

These anticipated total additions to the supply of generalist physicians from the state's residency programs would only be partially offset by projected attrition because of deaths and retirements (estimated to be 676 by 2005 and 1,436 by 2015). Therefore, even with no expansion of the state's generalist physician residency training capacity, the state's supply of generalist physicians can be expected to expand significantly over the next two decades.

The potential effect of changes in the state's generalist physician GME capacity. A focus of this report is to assess the need to expand the generalist residency training capacity in Wisconsin. Figure 2 provides information on the anticipated growth in the number of generalists per 100,000 population in the state through the year 2015, based on our supply projection model and population projections[10] and under the following scenarios:

- no changes in residency program capacity; and
- increases in the number of first year (PGY-1) generalist residency positions of 25, 50, 75, and 100, as of the year 1995.

Figure 2 indicates that, under a scenario of no increases in the number of generalist residency positions in Wisconsin, the statewide ratio of generalist physicians per 100,000 population would be projected to rise to about 69 in the year 2005 and would be about 71 per 100,000 in 2015, as anticipated annual attrition from the supply would begin to more evenly match annual residency output totals.

Increasing the number of generalist residency positions by 25 in 1995 would result in an increase in generalist physicians per 100,000 population to about 71 in 2005 and about 75 by 2015. Increasing the number of generalist residency positions by 50 in 1995 would result in more than 72 generalists per 100,000 population in 2005, and almost 79 per 100,000 by the year 2015.

Table 2. - Projected changes in Wisconsin generalist physician supply for the years 2005 and 2015.

Supply	Year 2005	Year 2015
1990 supply of generalists	2,894	2,894
Projected additions from WI residency programs*	1,500	2,500
Projected retirements of 1990 supply*	- 676	- 1,436
Projected supply	3,718	3,958

*See UW Health Policy Program Policy Paper 94-1, for specifics of how estimates were developed.

Increasing the number of generalist residency positions by more than 50 in 1995 would result in very dramatic increases ln the number of generalists per 100,000 population by the year 2010, increases which would continue to grow beyond the year 2015. Under two different scenarios of increases of 75 and 100, Wisconsin's overall supply of generalist physicians could be expected to reach approximately 83 and 87 generalists per 100,000 population, respectively, by the year 2015.

Conclusion

Caveats. Before considering the public policy implications of our supply and requirements projection models, we want to note a few caveats regarding the projection estimates we have presented. First, the assumptions of our projection models may or may not predict actual future trends. For example, we noted earlier that the supply projection model does not take into account what the migration rates of mid-career generalist physicians--in to and out of the state--might be over the next 20 years. It would be difficult to predict with any precision the extent to which either national or state physician workforce reform efforts or market forces may affect such in- and out-migration patterns in the future.

Second, our projections of total generalist physician requirements likely need small upward adjustments, to take into account the fact that not all qeneralist physicians will be actively involved in patient care activities. That is, there will be a need for some generalist physicians who are in full-time teaching, research, or administrative activities. Wisconsin data indicate that the number of total generalist physicians is approximately 105% of the number of patient care generalists, suggesting the need for an upward adjustment to our requirements estimates of about 5%.

Thus, the state's future requirements for generalist physicians are difficult to pinpoint with total precision. In modeling Wisconsin's generalist physician requirements for the future, therefore, we have used a fairly generous and wide range of generalist physician-to-population ratios (ie, 59 to 80 per 100,000 population), and assume that actual requirements will lie somewhere within this range.

Policy implications. What have our findings told us with respect to the need for the expansion of Wisconsin's generalist residency training capacity? The data presented suggest that Wisconsin's overall generalist physician supply in 1990 was at the low end of the requirements range we have considered (ie, 59 per 100,000 population), and was highly variable across different area of the state.

This relatively low generalist physician supply, however, does not automatically translate into the need for expansion of Wisconsin's generalist residency training capacity. As Figure 2 showed, even with no expansion of Wisconsin's generalist physician training capacity, the supply model projects that the statewide ratio of generalist physicians-to-population could rise to more than 70 per 100,000 population by the year 2015.

Before decisions are made about whether to expand qeneralist GME programs in Wisconsin, it would be important to consider what might be an appropriate "target" level of generalist physicians per 100,000 population. Depending on what requirements level was considered to be appropriate (eg, 59, 69 or 80 per 100,000 population), the implied policy implication would be either:

- that the present training capacity is sufficient (ie, no expansion is necessary); or
- that the number of generalist residency opportunities should be expanded by as many as 50 PGY-1

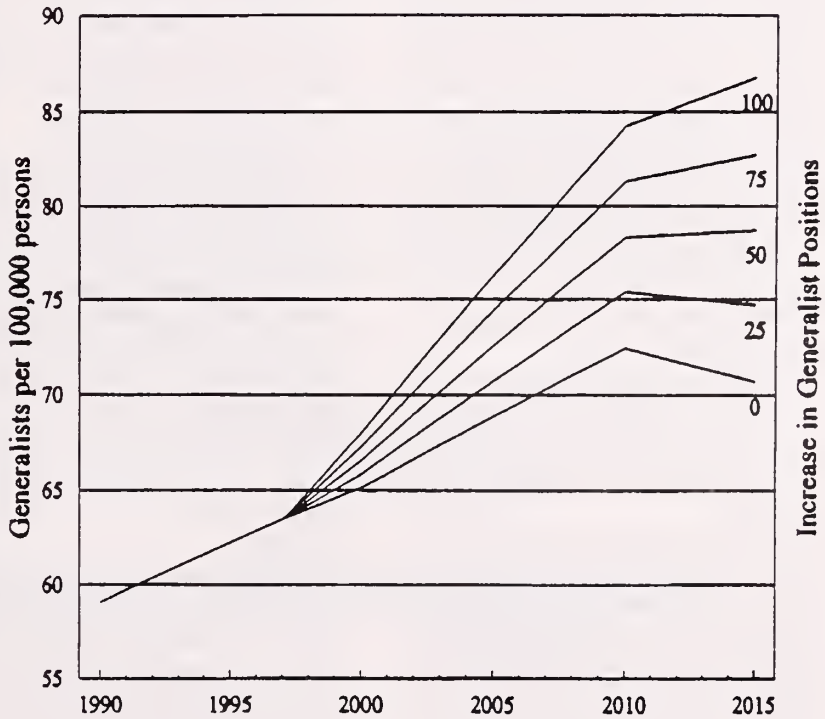

Fig 2. - Projected generalists per 100,000 population to the year 2015 based on current level of production and four levels of increases in generalist residency positions beginning in 1995.

positions.

Federal and state policy makers often seem to equate an increased production of generalists with correcting the geographic maldistribution of generalist providers, particularly in rural and inner city areas. Such expansion would not, of course, guarantee that the additional generalist physicians produced would actually locate in those areas of the state where they are most needed. Therefore, we would caution against relying solely on a public policy strategy of increasing generalist residency training capacity as the only way to resolve problems of medical maldistribution and under-service in Wisconsin.

Attracting generalist physicians to under-served areas requires public policy attention to key income concerns and administrative burdens of physicians locating in these areas. Research indicates that such income and administrative concerns rank higher as disincentives for physicians to locate in rural under-served areas than do such things as professional isolation and lack of community resources.[11] Key state and federal policies to address these maldistribution issues might include:

- programs for loan repayment and other forms of financial assistance;
- increasing insurance coverage for currently uninsured populations; and
- assuring that Medicare and Medicaid reimbursement rates are adequate to cover the costs of practice in under-served areas.

Such changes in federal and state policy affecting physician income may, however, still not be adequate to recruit and retain substantial numbers of generalists into under-served areas. Additional public policy attention should be paid to how the private sector--individual communities, hospitals, and health care plans--can structure the proper incentives to help attract generalist physicians to the areas of the state where they are most needed.[12] It may also be helpful to focus policy attention on ways to encourage private practices and health care systems around the state to participate in the training of generalist physicians, to expand the number of community-based training opportunities for medical students and residents.

Another strategy for addressing problems of medical underservice would be to increase the supply of other providers such as physician assistants and advanced practice nurses. From a policy perspective, it is important to understand the types of legislative changes surrounding scope of practice and reimbursement which may be needed to improve the distribution and effective use of these health care providers in Wisconsin. The Wisconsin Network for Health Policy Research is currently engaged in analysis of these public policy issues with regard to the supply and distribution of physician assistants and advanced practice nurses in Wisconsin.

It should be kept in mind that substantial increases in the supply of physician assistants and advanced practice nurses could offset any projected need to expand the supply of generalist physicians in the state. The level at which Wisconsin's qeneralist physician requirements could actually be offset by increasing the supply of other primary care practitioners has not been clearly established, however.

Finally, issues of generalist physician supply and requirements must be considered in the context of the total supply of physicians. For example, COGME has projected that there is likely to be an excess of about 120,000 specialists, nationwide, by the year 2020. To respond to this anticipated oversupply, COGME has proposed that the number of first year residency positions be limited to 110% of the total number of US medical school graduates each year, down from the current level of approximately 140% of US medical school graduates.[13]

In addition to limiting the number of residency positions, some observers feel that the issue of limiting the annual output of US medical schools (ie, cutting the number of yearly graduates) must also be seriously considered in the near future. These possible national physician workforce changes will call for further analysis of the projected supply of generalist and specialist physicians in Wisconsin over the next 20 years.

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13. Limiting the number of residency positions in this way would reduce the number slots available to medical students trained outside of the US.❖

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- Previous winners of the award are not eligible. *(The Medical Society will notify you if the doctor you nominate is a previous winner.)*
- The deadline for submitting nominations is **Feb. 3, 1995.**

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- Your name and address.
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A simplified method for treating Graves' disease with radioactive ^{131}I

Mohammad T. Masri, MD; Mary Menne, BS, CNMT; Brenda L. Rooney, PhD; and Robert H. Caplan, MD, La Crosse

We reviewed the medical records of 53 patients treated in 1986 for Graves' disease with moderate doses of ^{131}I. The cumulative incidence of hypothyroidism at 3 and 12 months after therapy was 38 and 80%, respectively. The hyperthyroidism, however, was rapidly cured and only 4(7.5%) patients required a second dose of ^{131}I. In a separate study of 21 patients with Graves' disease, we determined that the 4-hour ^{123}I uptake measurement was as reliable as the standard 24-hour test for supporting the diagnosis of hyperthyroidism. We also demonstrated that the 4-hour uptake accurately predicted the 24-hour uptake. Based on these findings and a review of the literature, we believe that either a 4 or 24-hour ^{123}I uptake study followed by the administration of a fixed dose of ^{131}I (10 or 15 mCi) provides a convenient and cost-effective method for treating Graves' disease. *Wis Med J.1995;94(1):21-25.*

Radioactive iodine has been used for treating hyperthyroidism for more than 50 years.[1] The treatment is simple, effective, safe and relatively inexpensive, and is considered to be the therapy of choice for Graves' disease by a majority of American thyroidologists.[2] Most physicians use formulas involving the estimated thyroid gland weight and thyroid uptake to choose a dose of ^{131}I that will cure the hyperthyroidism without producing hypothyroidism. Hypothyroidism, nonetheless, commonly develops after ^{131}I therapy and in some series approaches 50% 1 year after treatment.[3] To avoid hypothyroidism, several investigators have used low doses of ^{131}I.[4-8] Although these low-dose protocols have reduced the 1-year incidence of hypothyroidism, many patients remained hyperthyroid and required further therapy.[4-8] Furthermore, a 2% to 3% annual incidence of hypothyroidism occurred regardless of the ^{131}I dose.[3] Thus, the late incidence of hypothyroidism in patients treated with low doses of ^{131}I may be as high as 90%.[9] Recently, Nordyke and Gilbert reviewed a large series of patients with Graves' disease and concluded that a fixed dose of 10 mCi (1 mCi = 37 mBq) is the optimal ^{131}I dose to accomplish a cure in the average patient.[10] Fifteen mCi was recommended for patients with large goiters and patients with special clinical problems.

Since the development of specific and sensitive assays for thyroxine (T_4), triiodothyronine (T_3) and thyrotropin (TSH), thyroid uptake measurements using radionuclides are rarely used for diagnosing hyperthyroidism and are not necessary for calculating the dose of ^{131}I if a fixed dose is prescribed. The uptake measurement, however, remains useful for identifying the causes of hyperthyroidism that are associated with low (< 3%) iodine uptake such as silent thyroiditis, postpartum thyroiditis, thyrotoxi-

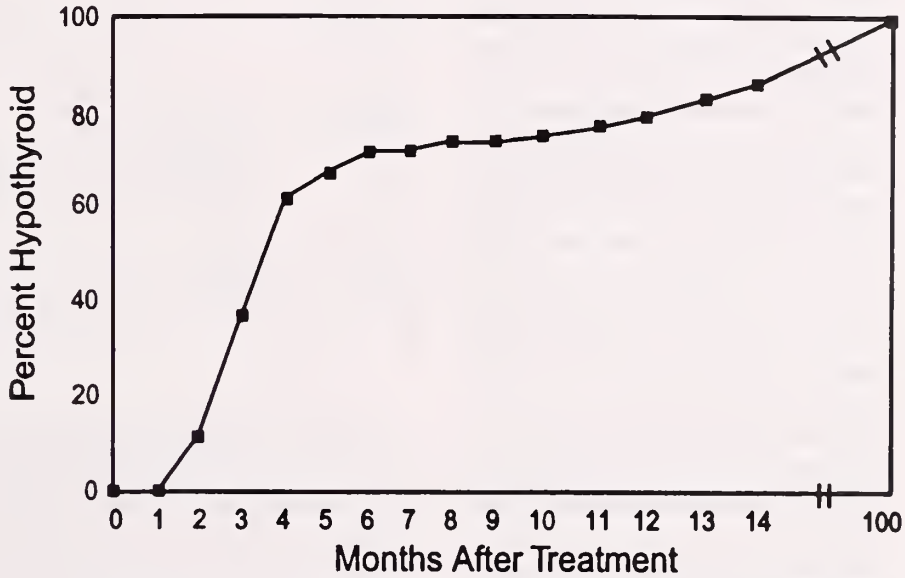

Fig 1.- Cumulative incidence of hypothyroidism in 53 patients with Graves' disease treated with ^{131}I.

From the Gundersen/Lutheran Medical Center in La Crosse. Dr Masri is with the from the Department of Internal Medicine. Menne is with the Section of Nuclear Medicine. Dr Rooney is with the Gundersen Medical Foundation. Dr Caplan is with the Section of Endocrinology. Reprint requests to: Robert H. Caplan, MD, 1836 South Avenue, La Crosse, WI 54601. Copyright 1995 by the State Medical Society of Wisconsin.

cosis factitia, and struma ovarii and is also convenient for identifying patients with Graves' disease who are inadvertently exposed to large doses of iodine.[11] Floyd et al demonstrated that an ^{123}I uptake measured at 4 to 5 hours was as useful for diagnosis as the standard 24-hour uptake test.[12] Recently, Hayes et al demonstrated that an early radioactive iodine uptake (3 to 6 hours) accurately predicted the 24-hour uptake, thus allowing same day ^{131}I treatment.[13]

In this study, we retrospectively reviewed the clinical outcome of patients treated at our medical center in 1986 with moderate doses of ^{131}I for Graves' disease. In a separate investigation of 21 patients with Graves' disease, we compared the 4-hour ^{123}I uptake to the 24-hour test and evaluated the formula derived by Hayes et al.[13] Based on our findings and a review of the recent literature, we suggest a simplified ^{131}I treatment regimen for patients with Graves' disease.

Methods

We reviewed the medical records of 53 patients treated with ^{131}I for Graves' disease in 1986. All patients were evaluated by an endocrinologist. The diagnosis of hyperthyroidism was made by clinical examination and by detection of elevated free thyroxine (FT_4) index or T_3 levels. In a few instances, a thyrotropin-releasing hormone (TRH) test was used when measurements of the FT_4 and T_3 were inconclusive. A diagnosis of Graves' disease was established by clinical criteria and by thyroid scintigraphy in a few cases. The dose of ^{131}I was calculated using the following formula:

$$\text{Dose of } ^{131}I \text{ (mCi)} = \frac{\text{thyroid weight (gm)} \times 100\ \mu\text{Ci}}{\text{24-hour } ^{123}I \text{ uptake (fraction)} \times 1000}$$

The basic dose was occasionally increased depending on certain clinical circumstances such as the presence of a large goiter, severe hyperthyroidism, severe ophthalmopathy, atrial fibrillation, severe nonthyroidal disease, or advanced age. Fifteen patients severely ill from hyperthyroidism or nonthyroidal disorders were treated with thioamides prior to the ^{131}I therapy. In these instances, the drug was discontinued at least 3 days before administering the radioactive iodine. Thioamide drugs (5 patients) or a saturated solution of potassium iodide (SSKI) (25 patients) were administered one week after ^{131}I therapy to patients with moderate or severe hyperthyroidism. The patients were evaluated at no less than 3-month intervals. Hypothyroidism was diagnosed if the FT_4 was low or the TSH concentration was elevated. Levothyroxine, prescribed for hypothyroid patients, was not withdrawn and thus the frequency of transient hypothyroidism was not established. Patients who remained hyperthyroid one year after treatment were given a second dose of ^{131}I.

In a separate study, 21 patients with Graves' disease had a thyroid uptake measurement of ^{123}I performed at 4 as well as 24 hours. The 24-hour uptake was estimated using the following formula derived by Hayes et al: 24-hour uptake = -55.7 + 73.2 log 4-hour uptake.[13]

Serum T_4, T_3, and TSH were measured by radioimmunoassay. Normal ranges were 5.2 to 11.2 µg/dl, 80-175 ng/dl, and < 5µU/ml, respectively. An FT_4 index was calculated by dividing the product of the T_4 and T_3 uptake by 100 (normal range, 2.2 to 4.6 units). Thyrotropin-releasing hormone tests were performed by measuring TSH before and 30 minutes after the intravenous injection of 500 µg of protirelin. A TSH increase of more than 2 µU/ml at 30 minutes was considered a normal response. Thyroid uptake measurements were performed by orally administering 100 µCi of sodium iodide ^{123}I and measuring the radioactivity at 4 and 24 hours with a Canberra Multichannel Analyzer thyroid probe set with

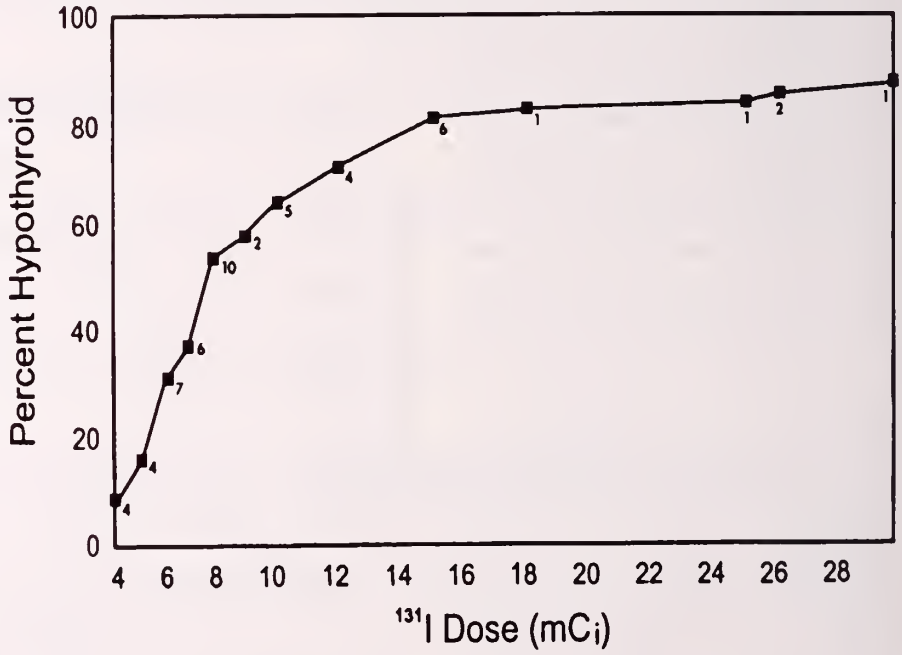

Fig 2. - Incidence of hypothyroidism relative to ^{131}I dose in 53 patients with Graves' disease. The numerals indicate the number of patients at each dose level.

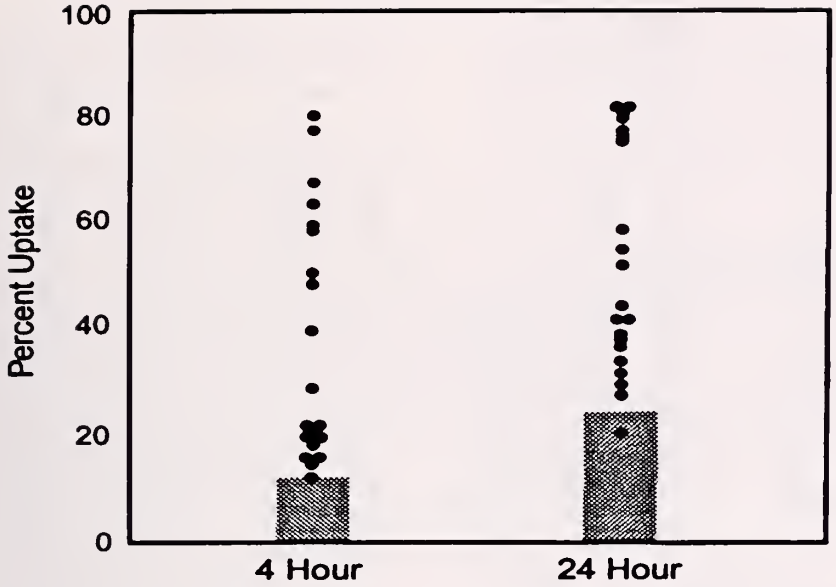

Fig 3. - Four and 24-hour ^{123}I uptake values in 21 patients with Graves' disease. The shaded areas indicate normal ranges.

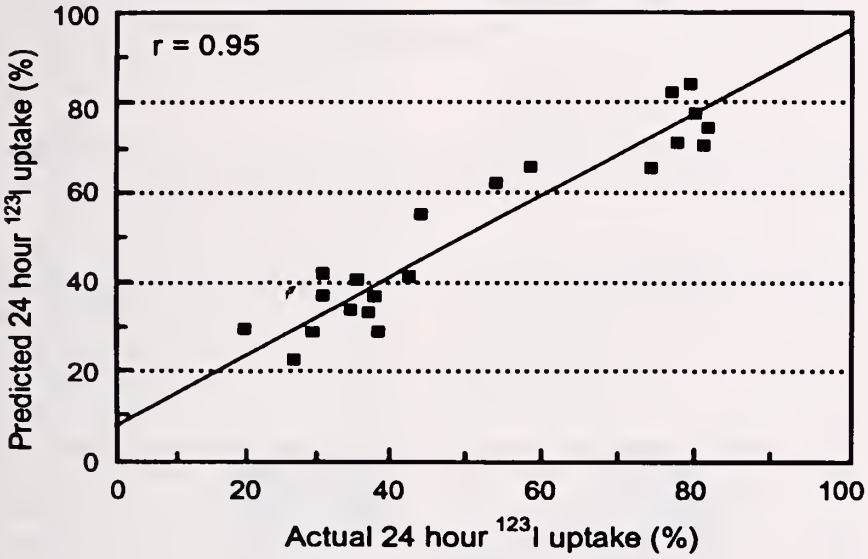

Fig. 4 - Predicted 24-hour ^{123}I uptake measurements obtained from 4-hour ^{123}I measurements using the equation derived by Hayes et al[13] (24-hour uptake = -55.7 + 73.2 log 4-hour uptake) closely correlated to actual 24 hour ^{123}I measurements (r = 0.95).

a 20% window centered over the 15 q keV gamma range. Counting geometry was maintained at 30 cm. Standard, standard background, thyroid and patient background measurements were obtained by counting for one minute over a lucite thyroid phantom containing a 100 μCi I^{123} capsule, an empty thyroid phantom, the patient's neck, and the patient's thigh, respectively. The thyroid uptake was calculated from the following formula:

$$\text{Percent thyroid uptake} = \frac{\text{Neck counts - thigh counts}}{\text{Standard counts - standard background counts}}$$

Normal 4 and 24 hour values were less than 12% and 24%, respectively.[14]

Results

Of the 53 patients with Graves' disease treated with ^{131}I, 46 were women and 7 were men. They ranged in age from 18 to 83 years (mean, 51 years). The cumulative incidence of hypothyroidism was 38 and 80% at 3 and 12 months after ^{131}I therapy, respectively (Fig 1). The frequency of hypothyroidism increased positively with the ^{131}I dose (Fig 2). Fifteen patients received more than 10 mCi of ^{131}I. After the administration of 16 mCi of ^{131}I, 80% of the patients developed hypothyroidism; larger doses produce only small increases in the incidence of hypothyroidism (Fig 2). Four patients, initially treated with 7, 10, 15, and 15 mCi of ^{131}I remained hyperthyroid; they were cured with second doses (6, 16, 29, and 29 mCi) of ^{131}I.

Four and 24-hour ^{123}I measurements were made in 14 women and 7 men with Graves' disease. They ranged in age from 14 to 72 years (mean, 46 years). The uptake results are summarized in Figure 3. Elevated ^{123}I uptake values were detected in 20 patients at both the 4 and 24 hour test intervals. The 4-hour ^{123}I uptake value accurately (r = .95) predicted the 24-hour value (Fig 4) and provided similar results to those obtained by Hayes et al.[13]

Discussion

The results of this study indicated that ^{131}I therapy frequently resulted in hypothyroidism and by 12 months 80% of our patients were receiving levothyroxine therapy. Some patients, diagnosed by detecting elevated TSH levels, may have had subclinical hypothyroidism and since we did not withdraw levothy-

roxine therapy, some may have had transient hypothyroidism. Regardless of the true incidence of hypothyroidism, the radioactive iodine therapy quickly controlled the hyperthyroidism in 92.5% of our patients. Although our basic ^{131}I dose was moderate (100 μCi per gram of estimated thyroid weight), we frequently increased the dose in older patients or individuals with large goiters, severe hyperthyroidism or serious nonthyroidal disease, with ophthalmopathy or atrial fibrillation. Fifteen patients were treated with more than 10 mCi of ^{131}I. Most endocrinologists use formulas involving the estimated gland size and thyroid uptake for calculating the dose of ^{131}I.[2] This method is flawed, however, since estimates of thyroid size, particularly of large goiters, are inaccurate and thyroid uptake studies do not measure ^{131}I retention.[10]

Because hypothyroidism is common after ^{131}I therapy, some investigators including one of us (RHC), attempted to reduce the frequency of hypothyroidism by using small doses of radioactive iodine.[4-8] These studies resulted in a low frequency of early hypothyroidism but up to 35% of patients remained hyperthyroid 1 year after therapy.[4-8] Many patients required as many as five additional doses of ^{131}I, thus increasing the morbidity of hyperthyroidism and adding to the cost and inconvenience of therapy.[15,16] Furthermore, delayed hypothyroidism occurred at a rate of 2% to 3% per year regardless of the amount of ^{131}I prescribed.[3] For instance, McCullagh et al reported that 90% of their patients were hypothyroid 17 years after treatment with 3 mCi of ^{131}I.[9]

Because of the inaccuracies of dosing formulas, Nordyke and Gilbert administered a fixed dose of ^{131}I to 605 patients with Graves' disease.[10] The cure rate with 3 mCi was 70% and 87% with 10 mCi (Fig 5). From a review of the literature, these authors reported the cure rate of 94% with an ^{131}I dose of 15.3 mCi. On the basis of these data, Nordyke and Gilbert concluded that the optimal ^{131}I dose for curing hyperthyroid Graves' disease was approximately 10 mCi. They increased the dose to 15 mCi for patients with unusually large thyroid glands and for special clinical circumstances.[10]

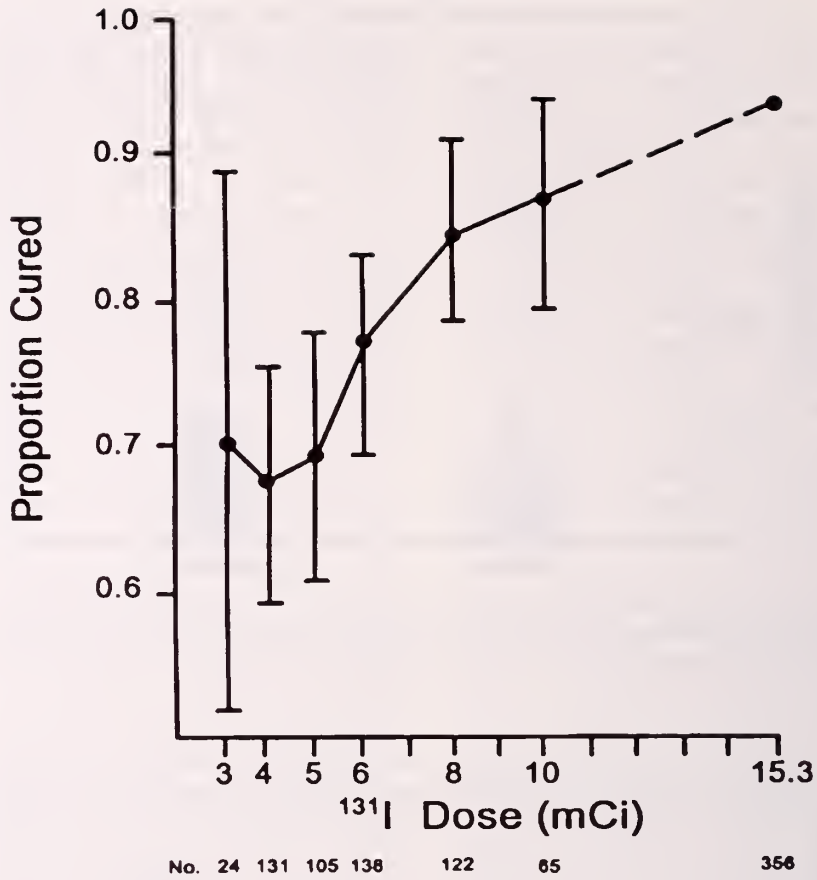

Fig. 5 - Cure versus fixed dose of ^{131}I. (Reproduced with permission from Nordyke and Gilbert: J Nucl Med 1991;32:411-416.[10] ©The Society of Nuclear Medicine)

Four (7.5%) of our patients including 2 patients initially treated with 15 mCi ^{131}I required two doses of ^{131}I before the hyperthyroidism was cured. This experience agrees with the common observation that some patients with Graves' disease fail to respond to even the so-called "ablative" dose of 15 mCi of ^{131}I.[1,10]

Some physicians administer therapeutic doses of ^{131}I without first obtaining radionuclide uptake studies. We do not advocate this approach, however, since some causes of hyperthyroidism are associated with very low uptake of radioactive iodine thus precluding treatment with ^{131}I.[11] In a previous study, for instance, 20% of our hyperthyroid patients had silent thyroiditis.[17] This disorder, which cannot always be distinguished from Graves' disease, is associated with very low radionuclide uptake studies. Since the uptake of radioactive iodine inpatients with Graves' disease is markedly suppressed by the administration of as little as 2 mg of iodine, unrecognized administration of this element in drugs, radiologic contrast media, food dyes or even the ingestion of food high in iodine content markedly suppress the uptake of ^{131}I, thus rendering this nuclide useless for treatment. The 4-hour uptake of ^{123}I was as useful as a 24-hour uptake for excluding those causes of hyper-

thyroidism associated with low radioactive iodine uptake and may be more convenient for some patients.[12]

In conclusion, we believe that a 4 or 24-hour ^{123}I uptake study followed by the administration of 10 or 15 mCi of ^{131}I as recommended by Nordyke and Gilbert, provides a convenient and cost-effective method for treating Graves' disease.[10] The need for levothyroxine therapy and life-long surveillance is required. More complex low-dose treatment programs, however, have a high frequency of treatment failure requiring costly additional therapy and still require long-term follow-up because of the high frequency of late hypothyroidism.

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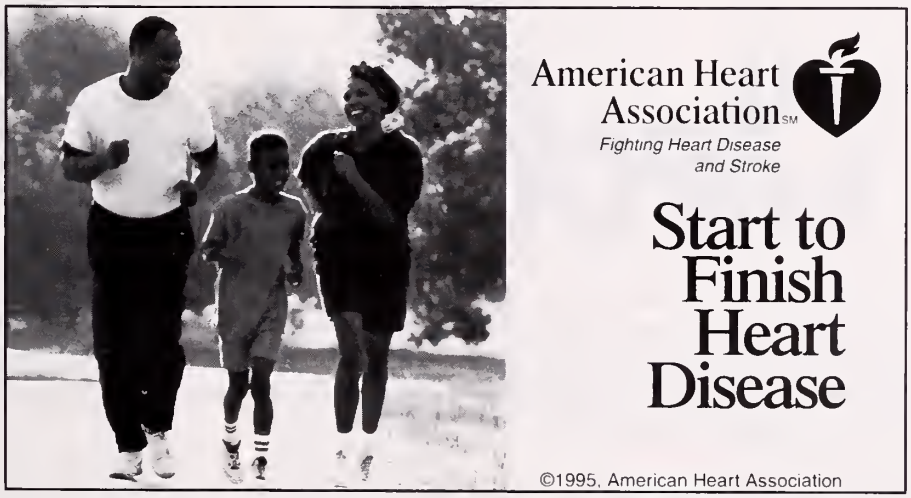

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CESF Medical Outcomes Research Project: Implementing outcomes assessment in a clinical setting

Peter Alles, CESF project manager

The CESF Medical Outcomes Research Project is distinct from other data collection projects in that it combines patient reports of quality of life and functional health status with physician information on process of care specifically for the purpose of assessing and improving quality. Unlike the efforts of non-physician organizations to collect health care data, medical outcomes research does not start with existing data collected for other purposes and attempt to extract answers, a process that tends to create more questions. Medical outcomes research creates a new set of data that makes it possible to move beyond the blunt instrument of morbidity and mortality reports, which do not provide feedback on how to improve quality. It also provides opportunities to participate in clinic-based research that emphasizes the whole patient population, rather than patients in specific health plans (see Keller article, p.33). Creating this new system of data collection for continuous quality improvement requires a plan for implementation that considers project goals and objectives, staffing needs, and technology requirements.

Creating a new system for data collection and analysis may appear to impose a major burden on physicians and office staff. Outcomes research survey instruments, however, are designed to ask patients questions that are normally asked during an office visit, which in some ways just represent a more systematic and efficient method of documentation. Furthermore, some outcomes research technology will enable physician offices to generate chart notes for use during patient visits as well as automating the process of generating referral letters.

Unlike other outcomes research efforts, the CESF Medical Outcomes Research Project will be a statewide effort that will enable physicians to compare and learn from statewide, as well as nationally collected, data. Nonetheless, while outcomes research is relatively new in Wisconsin, the physicians of Wisconsin have the advantage of being able to learn from the successes and difficulties of those who pioneered outcomes research, which in some cases included collection from multiple sites.

From the lessons of earlier outcomes research projects, we can discern basic guiding principles for implementation of outcomes research, including:

- setting clear goals and objectives;
- establishing an outcomes research team with appropriate resource commitment;
- limiting the initial project scope and evaluating the data collection process and results before expanding the scope; and
- starting with survey instruments that have been tested, validated, and for which there is a general consensus that the instrument is useful.

It was with these main principles in mind that the CESF Medical Outcomes Research Project has chosen to proceed with a pilot demonstration project, limiting initial 1995 implementation to 10 to 20 sites, using a core data set including a general health status questionnaire (SF-36 or HSQ), a health risk assessment form, patient demographics, and patient satisfaction. While the SF-36 and HSQ are useful for collecting information from patients with a many conditions, the demonstration project will emphasize four common chronic conditions; asthma, angina, depression, and low back pain. The SF-36 and HSQ are virtually identical and have become the standard core instruments for outcomes projects. Both forms are relatively short, have been validated and there is a base of useful comparative data for each.

Beyond the broad guiding principles established in previous outcomes research projects, implementing an outcomes research data collection effort at the clinical level requires an understanding of the process of collecting, checking and

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analyzing data, and the preparation that must occur prior to the project start.

Project planning

The first step in project planning is to establish clear goals and objectives. In doing so, physicians and administrators should ask several questions, including:

- what condition(s) do we want to study, and what survey instruments will we use;
- roughly how many of our patients have this condition, and should we include all of these patients or take a sample; and
- how are we going to use the data?

As noted earlier, the CESF Medical Outcomes Research Project is focusing on asthma, angina, depression, and low back pain for the initial demonstration project, using general health status and health risk instruments. Because the conditions chosen for the study are fairly common, and because office staff and physicians will want to test the collection process and become comfortable with the process, we recommend that physicians start with a small sample and include larger numbers of patients later.

Choosing to start with the general health status instruments (SF-36 or HSQ), rather than surveys designed for specific conditions, makes it possible for the project to take advantage of the availability of customized collection and analysis software. Several companies produce software and scanning products for the HSQ and SF-36 that will allow the data to be used either at the point of patient visit or in aggregate comparison with the data from other physicians and clinics.

Examples for readable and easily interpreted reports and graphs already exist and can be produced with the customized software or other products available in many offices. Similarly, health risk assessment data can be used at the point of service to develop an understanding of individual patient behavior and its relation to general health status, or could be used for comparison with the central CESF project data pool, or both. Aggregate health risk information can be useful for physicians and clinics in assessing expected patient health care needs and costs and developing a strategy for responding to capitation.

Project resources

Once decisions about overall project direction have been made, the next step is to assess resources that will be needed and start building a project team. For example, a clinic planning to use reports of patient health status during the patient visit will need a quick method of entering data and creating reports, and will likely need a personal computer, a scanner, a printer, and software capable of sorting data, conducting quick data analyses, and generating numerical and graphical reports. Although this technology investment is not required to participate, it may be considered as part of a long range plan to invest in clinical information systems.

The support of an information systems professional is helpful in planning for data collection and analysis and making an assessment of technology needs. There are, however, some basic questions that should be asked when planning the project, including:

- is a personal computer available, what are its capabilities for data storage, for connecting to a scanner, a printer, or transmitting data by modem;
- is the computer connected to a network, and can the network be used for storing data; and
- what software is currently available for storing and managing data, and can it be easily used with analytical and reporting software?

Although the initial demonstration project will involve a smaller patient sample, planning for the technology that will be used should also consider the long range goals of collecting data from a larger number of patients or adding condition-specific survey forms that combine patient and physician information on outcomes and process of care.

While the CESF Medical Outcomes Research Project will be heavily dependent on technology, and it is helpful to have an information systems professional involved in the process early, options are available for physicians who do not have access to these services. Several companies produce software and scanning equipment designed specifically to facilitate collection and reporting of SF-36, HSQ, and other outcomes survey data. If data transmission by modem to the central site presents problems, data can be loaded onto diskettes each week or month and sent by mail.

The other resource that is critical to the successful start of the CESF Medical Outcomes Research Project is physician and staff support and time. In addition to the physician and clinic administration, nurses, clerical staff, and information systems members of the project team should to have a good working understanding of the project and the theory it is based on because successful implementation depends on establishing a cooperative process for data collection and use.

Participating physicians will be provided with information on how to interpret reports generated from the HSQ or SF-36. Training for office staff members of the team will be described in a manual and include:

- how to select and enroll patients;
- how to maintain project records;
- how to use software and hardware for entering data, generating reports, and transmitting data; and
- how to schedule and administer follow-up surveys.

The demonstration project will begin with collection of information

from patients during visits to the clinic. As the project moves beyond then demonstration stage, however, additional procedures may have to be developed for conducting patient follow-up surveys by mail, telephone, or other media.

Survey administration

One global rule of data collection is that bad data pushes out the good data. The point of initial survey administration is the easiest point at which bad data can be transformed into good data or removed from the collection process. The potential payoff from quality data is worth investing time early in the project to start slow and test the survey administration methods at the clinic level. The commitment that each participating physician or clinic makes to ensuring data quality will enhance the value of the central data pool for use in comparing outcomes and processes of care.

As a result, before the actual demonstration project data collection begins, each participating clinic will begin with a short two week trial period in surveys will be administered to several patients each day, followed by an evaluation of how the process worked, and the quality of the data collected. Following any necessary technical or procedural adjustments, and possibly another trial run, the clinic will be ready to move forward in collecting data from a sample of patients for the chosen condition(s). The test will help physicians and office staff become comfortable with new technology and procedures before collecting data from a larger sample.

Periodic evaluations of data quality should be made throughout the life of the project.

Any step in the process can generate unforeseen obstacles that cannot always be planned for in advance. One common example is the problem of whether to enroll patients who are unable to self-administer

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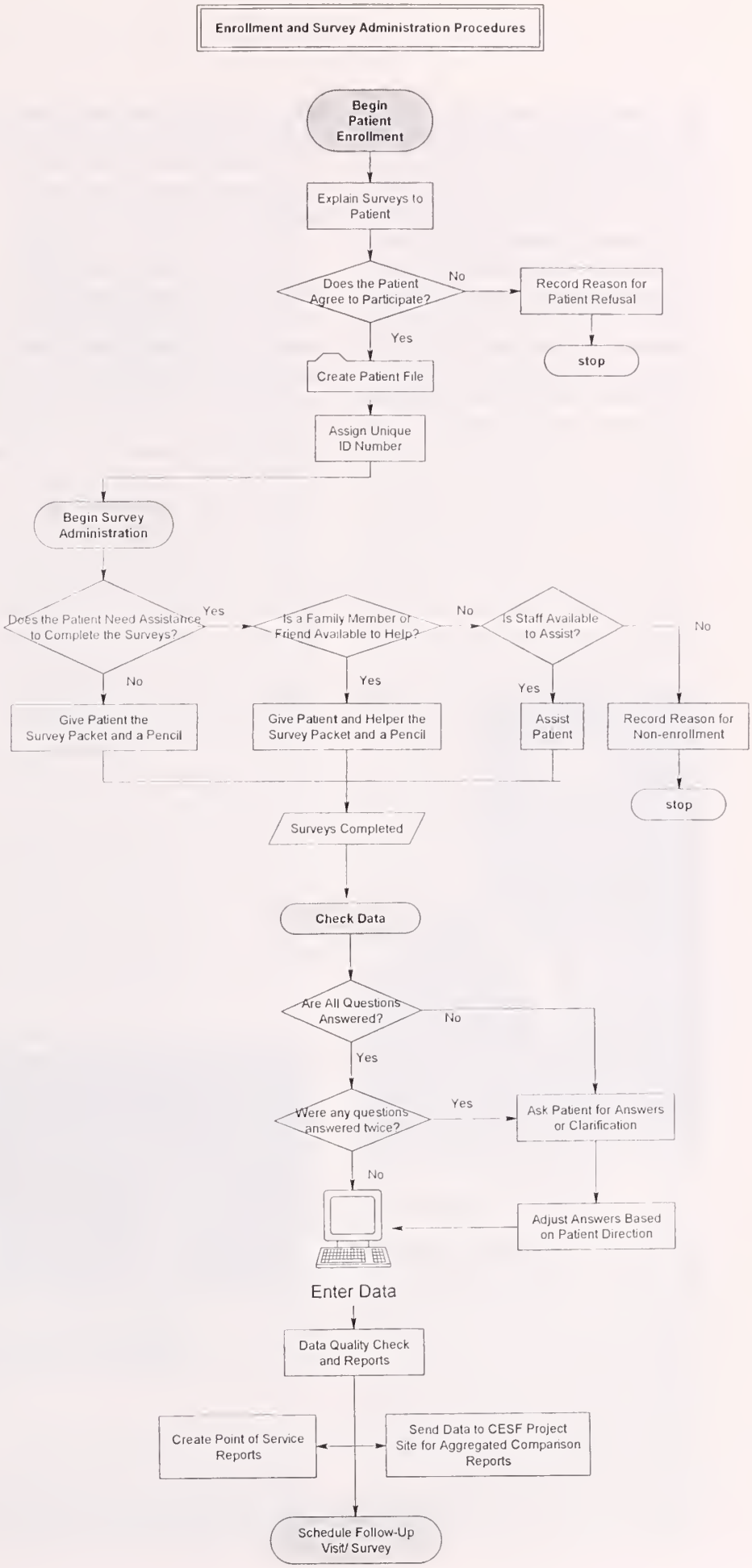

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the surveys for reasons such as poor eyesight, inability to read, or inability to read English adequately. Should office staff enroll a patient who appears to have difficulty reading, or who speak limited English only as a second language? Will they be unable to provide meaningful answers to the questions or will they receive help from a family members that skews their responses? The answer for the purposes of an initial demonstration project is that office staff will need to identify patients who are able to self-administer the survey and exclude others until a later time when these problems can be dealt with adequately. Other medical outcomes research projects have developed methods for managing these problems. For example, the SF-36 comes in several foreign language versions, and one way to collect data from persons unable to self-administer is to collect information on the source of help they received, whether it is office staff, relatives, or friends.

Another common example is when patients leave questions unanswered or include multiple answers for only one question. Before entering data, office staff will be responsible for checking surveys for completeness, and asking questions of patients to accurately complete unanswered questions or questions with multiple answers. If a scanner is used, office staff should also look for, and erase stray marks on the survey forms. Occasionally, patients who have difficulty making a decision may create their own response category. If a valid answer cannot be obtained from a respondent, then it may be necessary to erase the response and treat it as missing.

Other aspects of implementation are described in instructions and manuals for the Health Status Questionnaire and the SF-36, as well as in documents prepared by outcomes projects such as those by the Dean Clinic of Madison, and the American Group Practice Association. Included are procedures for providing a standardized explanation of the project to patients, checking data quality, tracking the timeliness of follow-up with patients, and establishing unique patient identification numbers. A more detailed description of the steps in the process of administering surveys can be seen in the figure, and will be included in instructions prepared for participating physicians and their office staff.

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useful information in the clinic or at the central CESF Medical Outcomes Research Project site, using technology discussed previously. The types of reports that will be useful for the demonstration project include descriptive tables and graphs for:

- administrative reports on timeliness of survey follow-up, data quality and consistency, persons refusing to participate, and persons receiving assistance with surveys;
- individual patient SF-36 or HSQ scale scores, health risk information or demographics; and
- scores for groups of comparable patients from data collected within a clinic by one or more physicians.

In addition, the CESF Medical Outcomes Research Project will generate reports with data collected from participating physicians and patients that does not identify patients, physicians or clinics. Individual physicians or clinics will receive reports showing their patient'sscores compared to overall scores for similar patients from other sites and comparing these scores with available national norms. These comparative reports will provide the basic information for the clinical study groups which will be formed to discuss the outcomes and process of care for each condition. ❖

PIC to support medical outcomes research

Shari Hamilton, assistant editor

CITING THE NEED for physicians to take the lead in health care quality assessment and quality improvement, the Physicians Insurance Company of Wisconsin has announced it will support the SMS Charitable, Scientific, and Educational Foundation's fledgling Medical Outcomes Research Project with a sizeable endowment and a matching grant.

The CESF pilot program on medical outcomes research will be launched in 1995 at 10 to 20 sites across Wisconsin.

In announcing the grants, Richard W. Edwards, MD, chair of the board of PIC Wisconsin, explained that the PIC board of directors views the CESF medical outcomes research project as important to maintaining the quality of health care in Wisconsin, as well as protecting physicians' ability to make decisions about patient care. Dr Edwards is a family physician practicing in Richland Center.

"We're all interested in improving health care," Dr Edwards said. "And this is one way of definitively proving our care is effective and establishing guidelines proving its effectiveness."

The CESF outcomes research project is the "first really concerted" program of its type in Wisconsin, Dr Edwards noted, and PIC officials felt the effort was particularly important to support because it is being directed by physicians. Many entities across the nation are looking at outcomes research, prompting concern among some physicians that such data will be used to establish guidelines that are more attentive to meeting budgetary goals than with providing quality patient care.

Proponents of the CESF project say this outcomes research will show that medical research in Wisconsin is second to none. The research has the potential to find out--from actual patients, they say, what works and what doesn't, so physicians can prove and improve quality.

"Outcomes research will hopefully decrease physician liability exposure," Dr Edwards said. "Ultimately, (the data gained) should be beneficial to PIC and its subscribers."

PIC is supporting the innovative research project with a 10-year gift of $25,000 per year, with the interest but not the corpus available to pay for operational costs. Also, PIC will donate up to $25,000 a year through a physician matching grant. For every $1 donated by a Wisconsin physician, PIC will donate $2.

Richard W. Edwards, MD

The success of the matching grant will also provide data on the commitment Wisconsin physicians are willing to make to outcomes research and demonstrate their desire to lead the way in continued excellence of patient care.❖

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Quality improvement foundations

Robert B. Keller, MD, Maine

Adapted from an address to the Medical Outcomes Research Symposium in Lake Geneva, Oct 14, 1994.

When I visited Wisconsin last year, I had the opportunity to visit the Columbia Hospital and discuss the concept and work of the Maine Medical Assessment Foundation and how our activities might have application here in Wisconsin. Over the past year, the State Medical Society has vigorously moved ahead with its own plans. You are to be congratulated.

Today, I will focus on the issue of "quality improvement foundations" (QIF), how they relate to your effort and why I think they are so important. Initially, QIF's were termed "regional professional foundations" (RPF). They were part of President Clinton's health care reform plan. This concept included much of what we have accomplished in the Maine Medical Assessment Foundation--small area variation studies, outcomes research, quality improvement projects, and the like. Also included in the RPFs, were new concepts advocated by Dr John Wennberg, including innovations such as lifetime learning, alternative physician practice activities, and support for rural practices.

Although national health care reform ultimately failed to materialize, several interesting events happened along the way. Dr Wennberg and I wrote a paper responding to the Clinton RPF proposal and amplifying our vision of the role of RPFs. That paper attracted the attention of a number of groups, including the American Medical Peer Review Association (AMPRA). You may recall that the PROs were slated to disappear in the Clinton plan. The AMPRA leadership had been interested in changing the mission of PROs for a considerable period of time. The leadership put together a coalition of interest groups to consider what bridges could be built between the RPF proposal and the peer review organizations. What resulted was a concept that was retitled "quality improvement foundations." QIFs had a stronger emphasis on state level activities than did the RPFs, but also emphasized the role of regional activities where they were relevant. Again, there was a strong resemblance to the methods and activities of the MMAF. At the end of the congressional session, the QIF concept was still gasping for breath but finally failed with the rest of health care reform. The federal initiative has ended for the moment, and it is now up to the states to try and accomplish health reform.

One might first ask the question: Should we continue to be interested in the concepts addressed by QIFs and is there any reason to move forward with this initiative? I contend that there is. In fact, we have always needed these kinds of organizations to evaluate practice patterns and outcomes of care and to stimulate physicians to think about how they practice. The problem is that we haven't recognized the extent of variation and uncertainty in physician practices until very recently. For many years, physicians and other health care providers have practiced in an environment in which we believed that we were providing care in appropriate and logical ways.

The individual who revealed the extent of uncertainty, confusion and variation in practice patterns was Dr Wennberg in his work with Alan Gittelson. Their method of small area variation analysis made clear to everyone, including physicians, payers, government regulators and patients, that the provision of health care in this country (and others) is markedly inconsistent. For example, patients living in one hospital service area in northern New England are 10 times more likely to undergo a lumbar spine fusion procedure, than if they live in another service area. The problem forboth physicians and patients is that they haven't previously had this information, and they have been unaware of their risk rate for this major surgical procedure. Beyond that, no one knows what the right rate of lumbar spine fusion should be.

As you begin to look at use data here in Wisconsin, you will find that variations exist here as well. I am sure they will be significant and disturbing to you. Much of the variation in practice patterns is based on a lack of solid scientific information on which to base decision making. There are many options for treatment of various medical conditions. Through delegated decision-making, physicians end up making choices for patients based on their own perceptions, beliefs, training, and community practice style--not on the basis of accurate, scientific information.

The MMAF began its work in the late 1970s when a physician named Daniel Hanley joined with Dr Wennberg to respond to the challenge of practice pattern variations which had been discovered through analysis of Maine's hospital discharge data base. Through a process of trail and error, we developed a se-

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Dr Keller is an orthopaedic surgeon and executive director of the Maine Medical Assessment Foundation. Copyright 1995 by the State Medical Society of Wisconsin.

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ries of specialty, oriented physician study groups. We found that general medical groups such as hospital medical staffs or county medical societies could not effectively comprehend and relate to the highly specialized nature of medical specialties. As a result, these groups could not focus on the variation issues within those specialties. A physician specialty group can focus clearly on the relevant clinical issues and begin to deal with the practice pattern variation data.

Through the specialty study group model, an educational, nonregulatory information feedback method developed. Over time, physicians have come to trust the work of the MMAF. We have promised not to publicly expose them and have never done so. We believe that the confidential, educational feedback method is justified. There are several reasons for this. First, the data may be inaccurate. Even the best data systems have flaws. Second, the right rate of use or provision of health care is generally unknown. In considering a 10-fold variation in lumbar fusion rates in northern New England, we cannot determine which of these several different rates is the "best" rate. The public assumption, of course, will be that the high rate is incorrect and physicians practicing in those areas will always be exposed to criticism. That may be incorrect. Third, public exposure of physician practice patterns will lead to defensive behavior and providers will instinctively tend to find ways around the system rather than participating in it.

On the other hand, there is external pressure on physicians to respond to the challenges of practice pattern variations. The hospital discharge data base available to us in Maine, like that in Wisconsin Office of Health Care Information is a public data base. Maine physicians are aware that other individuals and organizations can access that data base and create reports similar to ours. Other individuals and organizations in Maine are free to publicly release data at the level of hospital service areas and specific hospitals.

Physicians in the state have become interested in aspects of outcomes research beyond practice pattern variations and epidemiological analyses. Having accepted the fact that there is a large degree of uncertainty in medical practice, Maine physicians have become active participants in clinical outcomes studies to develop better information on which to make treatment recommendations. We have been involved in four prospective outcomes projects--all based on the issues raised by practice variations. They include a

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prospective study of patients undergoing TURP for benign prostatic hypertrophy; a prospective cohort study of women with benign uterine conditions; a prospective cohort study of patients with herniated lumbar disk and spinal stenosis treated both medically and surgically; and, finally, a prospective study of patients with carpal tunnel syndrome treated medically and surgically. All of these studies have or will provide important new information about the outcomes of these common clinical conditions.

I believe it is important for the profession to consider "population based health care." Health care has become increasingly segmented in this country. Physicians are being forced to deal with multiple health care plans. Each plan will have its own "quality" program and each plan may profile physicians by evaluating individual use patterns. I believe that physicians will be inundated by questions, data, and analyses produced by these plans. We know that these data are often statistically insignificant and adjustments for patient severity of illness, though improving, remain imprecise. We should be concerned that these separate, competing systems will overwhelm physicians and not truly improve the care of the populations they are supposed to serve. An organization such as a QIF can provide the necessary broad based data analyses and support for quality improvement projects. Because of its track record, the MMAF is widely viewed in our state as an organization with the credibility and skills to carry out these kinds of tasks. As new forms of health care organization develop in the state, the MMAF is frequently included, or mentioned, as an important resource for data analysis and quality monitoring.

Can the QIF concept be expanded beyond our borders in Maine? I believe it can. Your effort in Wisconsin is an example of this. We have also assisted and advised in the development of similar foundations in Hawaii, New Hampshire, and the Province of Manitoba.

What are the key ingredients in the development of a QIF? First, one needs good data. The hospital discharge data base that exists in Wisconsin is an excellent early start. The Maine program has also used Medicare data very effectively. Increasingly, there will be a need to access ambulatory health care information. Except for Medicare (and perhaps Medicaid) ambulatory data has been largely unavailable. New systems need to be developed and supported within the states. The State Medical Society and your new foundation can provide an important stimulus in the development and structure of health data systems. Next, you need an infrastructure to support your effort. Again, the Wisconsin foundation has made an excellent early start. One must have an organization to schedule meetings, analyses data, coordinate study groups, etc. Community-based practicing physicians will be interested in this project, but they will require an organization to stimulate, focus and coordinate their efforts.

You need leadership. A strong leader for the foundation and study group leaders who can recruit and stimulate their colleagues to participate in the process are essential. There may be some initial reluctance to the concept of looking at practice pattern variations and use data. Effective leaders can overcome this resistance and bring physicians into the process.

Finally, you will need funding. While not overly costly, QIFs must have adequate resources to develop staff, access and analyze data, and support study group activities. Funding resources can include health insurers, businesses, foundations, physician groups, and others. The MMAF has taken advantage of all of these approaches in its funding efforts.

In summary, despite the failure of national health care reform, the concept of QIFs remains vital. The efforts of the State Medical Society of Wisconsin are to be applauded. Physician leadership and participation will provide the tools you need to understand practice variations, respond to them, and maintain a leadership role in outcomes research and quality improvement initiatives.❖

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Creating the Medical Outcomes Research Project: an update

Sally Wencel , JD, CESF project director

In the August, the first article concerning the Charitable, Educational, and Scientific Foundation's Medical Outcomes Research Project appeared in this publication. The article that follows is an update on the project and augments the basic description of the project provided in the August article. Please refer to page 39 for more information about the project's history and the concept of outcomes management upon which the project is based.

In the intervening months since the SMS Task Force on Quality Assessment and Implementation of Practice Parameters reported its plan for implementing the Medical Outcomes Research Project in the August 1994 *Wisconsin Medical Journal*, the Task Force itself has been reconstituted as the Medical Quality Research Council of the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin. In October, the first annual Medical Outcomes Research Symposium was held in Lake Geneva and featured SMS President Richard Roberts, MD, JD, Wisconsin Commissioner of Insurance Josephine Musser and the executive director of the Maine Medical Assessment Foundation, Robert Keller, MD (see page XX), as well as a full slate of experts in quality assessment. The newly named Medical Quality Research Council focused on developing the detail of the Medical Outcomes Research Project design and implementation strategies. Finally, project staff have been retained to assure the project moves forward. This article reports on the planned direction of the Medical Outcomes Research Project for 1995.

Collecting core data

The project is slated to begin early this year. As a start to this statewide voluntary collection effort, the focus is on acquainting project participants ("pilot sites") with the core data sets consisting of the following instruments: the SF-36 or Health Status Questionnaire (HSQ), the health risk inventory, and demographic (personal characteristics) survey. An optional addition to this data is the Group Health Association of America (GHAA) Patient Satisfaction Questionnaire. Reported to and maintained in strict confidence in the project data base, this information will establish the baseline data for patients enrolled in the initial studies. Pilot sites currently engaged in outcomes management will have the option of providing this initial data set as well as the clinical information piece discussed in the following section.

This patient reported core data has great practice management potential, as attested to by physicians who are currently involved in collecting these data. For one example, obtaining patient health risk information will becomes more crucial as health plans place more risk on physicians through capitation contracts. By taking capitated payments from managed care plans and health care purchasers, physicians will become health insurance underwriters and will need to develop information systems that capture actuarial data necessary to understand the financial risk they will be undertaking. Also, this additional information from patients can be immediately integrated in to the medical record and provide an additional dimension to physician-patient and physician-consultant communication. Finally, data will provide physicians with valuable information upon which to assess practice guidelines, critical pathways and other practice algorithms as well as provide an additional gauge of practicequality. This last factor will become more important as guidelines become institutionally imposed and physician practice profiling becomes more commonplace.

Clinical data phase-in

Clinical information collection surveys (Technology of Patient Experience or "TyPE" forms) will be disseminated to pilot sites once data collection protocols and procedures are established and in operation. Collection protocols will emphasize data ownership by the pilot sties, data confidentiality and security, and project participant involvement in data management and assessement. This phase-in will allow the use of study groups to review and select the clinical information collection tool determined to be the most valid available.

As a starting point, the following studies are targeted for study: asthma, angina, low back pain, and clinical depression. These clinical conditions represent maladies treated by a wide range of physicians in different practice settings, are often treated in a widely varying manner, may be diagnosed through the SF-36 or HSQ (ie, depression[1]) and are chronic conditions treated primarily on an outpatient basis. One of the basic premises of the project is to capture important primary data sources[2] that are available only through ambulatory clinical practice. Traditionally, these data have not been collected in an organized,

format validated manner. This emphasis on ambulatory data is not exclusive, however, and hospital based outcomes projects are specifically contemplated in the project design.

In addition to this intial focus, anyone interested in conductinga clinical study may use the pooling capability of the project and commence data collection for other clinical studies not targeted for the project's first year. Through this cooperative research approach, physicians and facilities interested in a clinical research project other than the four recommended for the first year may begin now rather than later. In fact, if there is great interest in other clinical projects, those clinical projects may be added to the first year plan. The reason for phasing in clinical information over time and limiting the number of initial clinical projects is to keep data manageable and better assure the project's ability to assess, analyze and disseminate the data collected.

Although the four conditions listed above will be targeted, the project will make efforts to include nay core data submitted by pilot sites that are willing to stay within the data collection protocols established by the project regardless of their intent to incorporate the clinical information portion in the future. From discussions project planners have had with clinicians using the SF-36 or HSQ piece, this information alone at the point of service can greatly enhance medical decision making and has utility as a new part of the health care record. Also, there is great potential for this regional demographic and health status data to become an invaluable health research and planning tool and a method by which to establish a baseline population health census from which to compare over time.

Project committees

To effectively accomplish the tasks ahead, the CESF Medical Quality Research Council will establish advisory committee groups to develop plans, protocols and policies for the following areas:

- confidentiality and research ethics;
- data quality assurance and assessment;
- clinical implementation and training;
- clinical study groups(asthma, angina, low back pain, and depression);
- education; and
- finance and grants.

The advisory committees will be

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comprised of project participants, council members, experts and interested persons. The council will assign goals and objectives to each committee corresponding to its mission. Committees will report to the council on a regular basis and make recommendations for the council's approval.

The Medical Quality Research Council will be providing periodic reports on the progress of the Medical Outcomes Research Project, which will be published in the *Wisconsin Medical Journal*. The council invites SMS members and affiliated health care providers and managers to contact the project staff for more information about the Project or it interested in participating in the development of the project through the committee process.

Notes

1. Berwick D, Murphy J, Goldman P, et al. Performance of a five-item mental health screening test. *Med Care*.1991;29:169-176.
2. Primary data sources refers to information collected directly from the patients or patient health records as opposed to secondary data sources, such as insurance claims forms. Currenlty, most data collection occurs at the secondary source level, such as the Wisconsin Office of Health Care Information, which collects information abstracted from insurance claims and hospital discharge summaries.❖

The SMS-CESF Medical Outcomes Research Project

Jerry M. Ingalls, MD, Sally L. Wencel, JD, and Peter J. Alles, Madison

After reviewing the environment of cost, quality data collection and analysis, the State Medical Society of Wisconsin Task Force on Quality Assessment and Implementation of Practice Parameters concluded it is critical for the SMS to take a dynamic role in sponsoring the development and use of medical outcomes research. The initial emphasis will be on chronic diseases and health conditions representative of a large percentage of the Wisconsin patient population and involve physicians from diverse practice settings. The physicians of Wisconsin have a singular opportunity to seize the day by supporting and participating in a non-proprietary, regional study of patient medical outcomes. Reprinted from*Wis Med J.1994;93(8):433-437.*

The SMS Task Force on Quality Assessment and Implementation of Practice Parameters was appointed by the Board of Directors in September 1991 to ensure that Wisconsin physicians assume a knowledgeable role in the continuing discussion of quality medical care. The task force was also given the responsibility to develop a plan for the SMS in the assessment of quality and the implementation of practice parameters.

With this charge as its initial focus, the task force set forth with its own assessment of the state of the art of quality assessment activities. Among the presenters was a representative of what was then called InterStudy, a twin cities think tank founded by Paul Ellwood, MD. Although impressed with the strides made by InterStudy in pioneering this new approach to quality assessment called the Outcomes Measurement System, the task force concluded the time was not ripe for the SMS to endorse this quality assessment process. On July 18, 1992, the task force recommended to the Board that the SMS should be involved in the following activities:

- serve as a clearinghouse for the dissemination of information about practice parameters;
- assume a leadership role in educating physicians about quality improvement and review; and
- monitor the development of practice parameters, quality improvement and outcomes management.

The Board of Directors adopted the report and recommendations which served as the SMS plan for addressing medical quality assessment issues. Having accomplished its task, the task force was allowed to expire.

The 1993 SMS House of Delegates approved a resolution directing the

Continued on next page

Dr Ingalls is chair of the SMS Task Force on Quality Assurance and Implementation of Practice Parameters and a member of the SMS Board of Directors. Wencel is the SMS assistant corporate counsel. Alles is an SMS policy analyst. Reprint request to: Sally Wencel, JD, State Medical Society of Wisconsin, PO Box 1109, Madison, WI 53701. Copyright 1994 by the State Medical Society of Wisconsin.

Continued from preceding page
SMS to "take aggressive leadership in the development, dissemination, and education regarding clinical outcomes research to validate practice guidelines by which to address practice variations and leading to appropriate change." This resolution gave a powerful direction to the SMS to take an active role in addressing the uncertainty surrounding whether practice parameters or guidelines and maintaining accountability to society for the development and implementation of quality assessment activities in the clinic. The task force was reconvened with this new direction in mind.

After reviewing the environment of cost, quality data collection and analysis, the task force concluded it is critical for the SMS to take a dynamic role in sponsoring the development and use of medical outcomes research. Specifically, the task force concluded the SMS should develop a medical outcomes research project to be implemented on a statewide basis.

There were several key reasons for this conclusion. First, the 1993 House of Delegates gave this edict. Second, there is an ever-growing interest expressed by both the public and private sector in practice guidelines and outcomes measures, although perhaps not with a thorough understanding of either concept and its proper application. As one example, the term "outcomes" is being frequently applied to data analysis using the gross parameters of mortality and morbidity.

Beginning in October 1993, HCFA redirected its contracting PROs to analyze physician practice patterns, benchmark facilities with good outcomes, and to develop practice guidelines, among other new quality improvement initiatives.[1,2] By defining the mean for the bell curve distribution of physician practice patterns, the assumption is that moving practices in one specific direction, ie, fewer radical prostatectomy procedures per 1,000 patients, will improve patient outcomes. Similarly, health insurers are applying critical pathways or practice guidelines to define cost-effective care. The task force expressed concern that data is not being collected from the clinicians and patients to support the conclusion that good care results from the application of these "quality improvement programs."

Another concern outlined by the task force is the current lack of support for physicians engaged in provider contracting to demonstrate their good record with patient care. With the specter of being left out of major managed care provider networks for "quality reasons," physicians voiced the need for this sort of quality assessment tool to maintain their ability to practice medicine. Primary to this project (as described later) is the emphasis on providing aggregate data over patient populations and practice settings. As the science of outcomes research becomes more sophisticated, additional data features will be available to accurately risk adjust for comorbidities and other important distinctions in the patient outcomes data.

Finally, there is an important public policy objective served by medical outcomes research as its potential can be explored and expanded in the future. As medical outcomes research is fostered through this project, the profession may be moved toward the concept of a regional professional foundation[3] to develop lifetime learning, to ensure quality health care deliver, to foster collaboration between health plans and providers, to disseminate information about successful quality improvement programs, practice guidelines and research findings, among other quality of care promotion activities.

The task force made its recommendation to the SMS Board in February 1994 for the SMS to develop a medical quality research foundation, organized as a separate scientific foundation or folded into the existing Charitable, Educational and Scientific Foundation, and commence a medical outcomes research project. After accepting this report, the Board of Directors recommended this project for the 1994 House of Delegates' approval, which was given on April 15, 1994.

Medical outcomes research

It is important to point out what medical outcomes research is not: It is not based on information about the cost of care by extracting information from bills for health care. With ever-increasing frequency, the term "outcomes" is used by a variety of speakers with respect to data collection and analysis to determine whether "quality" health care services are being provided or purchased. Most often, the focus of data collection efforts have been on determining the "cost outcome" of health care rather than the patient's health outcome.

This emphasis is due to several factors. Perhaps the primary reason for this emphasis is that claims data has been the most traditionally available source of data. Starting with the Medicare program, claims data have been analyzed with the purpose of controlling program costs, including ferreting out provider and recipient fraud. The National Claims History System, a HCFA data reporting system that combines both Part A and Part B claims in a common file, has collected claims data for years and provides a wealth of both inpatient and outpatient payment information.

The other key reason for the emphasis on claims data for "outcomes" analysis is that medical care costs have been the major concern of those making the decision to collect data. In Wisconsin, the Office of Health Care Information has been collecting hospital discharge information since 1991, and began col-

lecting ambulatory surgery data in 1993. The data analysis emphasis has been on mortality and morbidity comparisons, cost and length of stay measures per DRG (diagnostic related group). Although this Office of Commissioner of Insurance administered agency is attempting to glean other analysis from claims data, it is unable to do so because of the questionable integrity of this data.

Private carriers, managed care organizations and employer coalitions have also entered the data collection field and have also focused on claims data. The purpose of this data analysis is primarily to track health care program costs rather than quality data. The explanation has been that high cost care is often low quality care.

Within Wisconsin, there has been no statewide analysis of the effect of cost-based practice guidelines on patient care other than the information yielded from claims data. These quality measures are gross in nature--mortality, morbidity, and readmission--and tell little about the patient's status.

From the task force's perspective, "outcomes" data based on claims information is inadequate for quality improvement purposes. While the use of this data by managed care plans and insurers to monitor costs is certainly justified, data yielded by claims review does not tell physicians how to provide better care to patients. Also, there is an important use of this analysis to determine procedures or the treatment of certain health conditions in which there is wide variation. Mere variation, however, does not answer the question of what is the appropriate level of services. (See, Hoover N. *Wis Med J.1994;93(8):429-431.*) The focus is clearly on cost effective care and there is little scientific evidence offered to demonstrate that, for example, shortening hospital length of stay does not adversely affect the patient's health outcome. Claims data does not capture the full health care picture. Moreover, it has little credibility with practicing physicians and therefore is not effective in changing physician practices other than to comply with managed care guidelines.

Outcomes management system

As a result of the increased emphasis on claims data based "outcomes" information, the SMS task force reviewed the emerging science of medical outcomes research as originated by Paul Ellwood, MD, (described above) and now being pro-

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Continued from preceding page
moted by the Health Outcomes Institute. This outcomes measurement system emphasizes the use of patient-reported information on health status and quality of life in conjunction with clinical and process measures reported by the patient's health care provider. The purpose of this study is to compare, account for, and manage the effects of ordinary medical care on patients' clinical status and quality of life.

Unlike claims data analysis, outcomes measurement and research provides one of the three critical features of a quality improvement program.[4] To put it another way, outcomes research establishes the effectiveness of medical care in the "real world" rather than determining the likelihood of effectiveness through the well-controlled conditions of clinical trials.[5]

As he described his patient-based clinical outcomes system,[6] Ellwood realized that health care costs were climbing, yet there was no way to accurately measure the real value of medical treatment. There was no proof that an extensive and costly medical treatment would result in better quality of life for that patient. He reasoned that costs would never be truly brought under control and quality would never truly be assessed until physicians can determine that x treatment will yield y outcomes at z cost. Only then can a rational, educated decision about treatment be reached. He challenged the medical community to participate in the development of his Outcomes Management System (OMS) and use its analysis to:

- follow the natural progression of health conditions;
- assess and choose the most appropriate therapies;
- establish standards for treatment of specific conditions;
- estimate resources to be used in treating conditions;
- predict the cost of care; and
- select the most efficient and effective providers of care.

This system, in other words, is a management tool--providing the information to feed back to physicians to improve the way in which they deliver health care to patients based on what is shown to work for patients.

The OMS is simple in design. It consists of simple questionnaires and data collection protocols to be used in collecting data in a common format across patients, settings and conditions. The questionnaires consist of the health status questionnaire ("HSQ") that collects from patients self-reported quality of life, satisfaction, demographic, health behaviors and co-morbidity data. Through testing and retesting, a baseline for responses from healthy persons has been established against which the responses of patients with a medical condition is gauged. The closer the responses of the patient receiving treatment to the healthy baseline, the closer to "health" the patient appears to be.

The other information tool is the Technology of Patient Experience or "TyPE" form. This form is condition-specific and completed by patients and health care providers to collect demographic, comorbidity, and quality of life information as well as the clinical measures of a patient's condition and outcome. There are currently 16 TyPE forms available, including angina, asthma, cataracts, chronic obstructive pulmonary disease, chronic sinusitis, depression, diabetes, hip fracture, hip replacement, hypertension and lipid disorders, low back pain, osteoarthritis of the knee, prostatism, rheumatoid arthritis, stroke and substance use disorder (alcohol).

Data collected in a common format allows pooling of data and comparison of experience. An important feature of OMS is the emphasis given to patient-reported functional status and quality of life along with simple clinical and process measures. The volume and kinds of data required within the outcomes measurement system are kept small, making it more practical to collect these data as part of everyday practice. The outcomes measurement tools are placed in the public domain so as to minimize barriers to their use. Examples of current studies using the OMS include the American Group Practice Association in cooperation with over 50 member clinics, the Managed Health Care Association, HealthSpan, Inc., and the State of Oregon Medicaid Program.

At this writing, the task force is in the process of identifying health conditions to study to initiate the project. The initial emphasis will be on chronic diseases and health conditions representative of a large percentage of the Wisconsin patient population and involve physicians from diverse practice settings (ie, specialty clinics and multispecialty clinics, large and small medical offices). Also, the health conditions will be treated primarily on an outpatient basis, which would further distinguish this project from current data analysis projects with the traditional inpatient claims data approach. As interest and participation in this demonstration project grows, the task force will expand the research to include more health conditions.

Resources needed

The equipment and technology needed to implement an outcomes study in the clinic setting varies on practice size, patient population to be included and number of physicians participating. For a small patient study, paper forms may be collected and mailed or faxed to the SMS for data collection and analysis purposes. Larger medical groups may be currently collecting outcomes data and may submit data tapes or transmit the information via modem on a "real time" basis. As the project is implemented, the SMS will provide trainers and other

technical support and assistance to project participants. Also, there is an expanding commercial interest in providing outcomes research technology and support and participants may elect to obtain both the technology and data analysis tools to perform the data collection and analysis on site. This internal data function may quickly enhance the clinic's quality improvement activities.

The process

Enrollment and record preparation. Each participating physician office or clinic ("participants") will select patients for enrollment in the study and establish files for information collected. These files can be made part of each patient's medical records, if desired. To ensure confidentiality and maintain a link between raw data and the patient medical records, physician offices will assign a code number to each patient enrolled. A brochure containing information on the project's purpose, intended uses of data, and methods for keeping individual responses confidential will be given to each patient at the time of enrollment.

In addition, a log will be maintained for patients choosing not to participate in the project. Knowledge of characteristics for non-participating patients may enable the project coordinators to determine if there is any systematic bias in enrollment. Patient comments on their reasons for not participating could also yield useful information with which to fine-tune project methodology. For example, if a significant number of patients refusing to participate indicate they are concerned about confidentiality, the project coordinators could use this information to consider adjustments to the informational brochure or other aspects of the research process.

Transmitting data. The demonstration project will be limited in scope and will make use of a general health status survey. Participants may choose to send survey data in several ways for the initial project. The forms can be mailed to the SMS as completed, or in batches. Alternatively, participants may choose to send surveys by fax, keeping the originals. Fax and scanning technology has improved markedly in recent years, reducing the incidence of errors related to transmission quality and making it possible to quickly screen forms for possible errors during the scanning process.

As the outcomes research progresses beyond the demonstration project, physician offices and clinics choosing to participate may have to decide whether to purchase software and scanning equipment designed for outcomes research. Those choosing to do so will be able to enter their own data and send it to the SMSW by modem or on diskette.

The symposium

A specific project under way is to hold a Medical Outcomes Research Symposium Oct 14, 1994, in Lake Geneva at the Grand Geneva Resort and Spa. This symposium is designed to provide physician and health care industry leaders information about the SMS Medical Outcomes Research Project, to reach out to the health care delivery system about the project and to encourage participation of medical practices throughout the state. Category I CME credits are being applied for to award physicians who participate in this conference.

Conclusion

The physicians of Wisconsin have a singular opportunity to seize the day by supporting and participating in a non-proprietary, regional study of patient medical outcomes. The task force that recommended the SMS-CESF Medical Outcomes Research Project concluded that this system of data collection and analysis is the only viable means of performing quality assessment and is the critical but often missing link in a medical quality improvement program. While housed in the CES Foundation of the SMS, the project's emphasis is on cooperation between various organizations, health care delivery systems and local and national outcomes measurement projects. To learn more about the project, physicians and health care delivery leaders are encouraged to participate in the Medical Outcomes Research Symposium on Oct 14, 1994. For more information about the project or the symposium, please call the SMS: 800-362-9080 or, in the Madison area, 257-6781.

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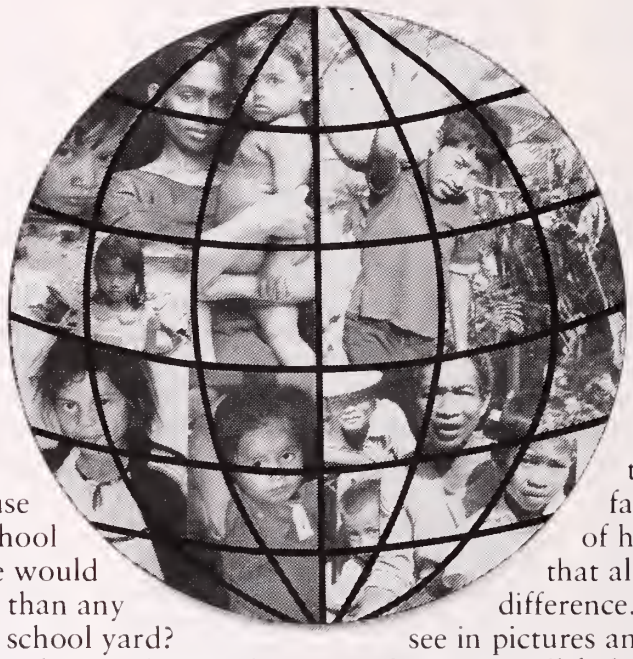

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Public health

Medical students health habits: Do future physicians have healthy lifestyles?

Patrick McBride, MD, MPH; Mary Beth Plane, PhD; Gail Underbakke, RD, MS; Rebecca Hill, BS; and Donald Wiebe, PhD, Madison

MUCH OF THE premature morbidity and mortality in Wisconsin is attributable to personal behaviors including smoking, alcohol consumption, failure to use seatbelts, lack of exercise, and poor nutrition.[1] In a recent evaluation, 28% of Wisconsin adults were overweight, 23% smoked, and 55% were not physically active.[1] These are similar to national figures.

Physicians play an important role in encouraging their patients to adopt and maintain healthy lifestyles. The effectiveness of physician advice has been well documented and people have frequent contact with their physicians. Physicians, however, often fail to screen patients for these risk factors due to a variety of factors including attitudes, counseling skills, and a variety of practice constraints.[2]

Physicians with positive health habits, and favorable attitudes regarding the effectiveness of behavior change counseling, screen and counsel more patients than physicians with negative attitudes and habits.[3,4] We collected health information on University of Wisconsin medical students and provided students with individual health and risk feedback to encourage students to develop healthy lifestyles. The group data was used as part of a new prevention curriculum covering chronic disease risk factors, nutrition, epidemiology, and clinical preventive medicine.[5] We report here on the health habits and risk factors of these future physicians.

The public health column is not reviewed by the *WMJ* Editorial Board; it is coordinated for the *WMJ* by Patrick L. Remington, MD, of the Wisconsin Division of Health. From the Preventive Cardiology Program, Department of Family Medicine, and the University Hospital Clinical Laboratory (Dr Wiebe), University of Wisconsin Medical School, in Madison. This work was supported by a Preventive Cardiology Academic Award, NIH Grant No. 5 K07 HL01936-03 and the University of Wisconsin Medical School. Reprint requests to: Patrick McBride, MD, Department of Family Medicine, 777 S Mills St, Madison, WI 53715. Copyright 1995 by the State Medical Society of Wisconsin.

Methods

During a 5-year period (1987-1991), first-year medical students were mailed a standardized student health survey used in NIH research of medical student health behavior. Nutritional information was collected using a 3-day food record and was analyzed using the Nutritionist III program for 2 years. For the remaining 3 years, the nutritional information was collected and analyzed using the Block food frequency program. Students voluntarily attended a screening held prior to morning classes within a few weeks of starting medical school. Measurements at the screening included height, weight, blood pressure, and fasting blood lipoprotein levels (total cholesterol, high density lipoprotein, triglycerides, and calculated low density lipoprotein). Summary statistics were generated using the SPSSX statistical analysis program.

Results

Over the 5-year study, 511 (72% of the potential population) participated. The health survey was completed by 428 students, 449 had lipoproteins tested, and 391 students completed nutritional assessments. Three hundred and forty students completed both the health survey and nutritional assessment, and had lipoproteins tested. The remaining 171 completed either 1 or 2 parts of the study. The sample included students with the following charac-

Table 1. - Medical student risk factors.

Cigarette smoking	
Current smoker	2%
Smoked and quit	10%
Never smoked	73%
No response	16%
Physical activity/week	
0 episodes	5%
1 - 2	24%
3 - 7	51%
8 - 12	3%
No response	17%
Seat belt use	
Never	3%
Sometimes	17%
Always	64%
No response	16%
Cholesterol	
Total <200 mg/dL	76%
Total <200-240 mg/dL	10%
Total > 240 mg/dL	2%
HDL <35 mg/dL	8%
Did not participate	12%
Body mass index	
BMI <25	64%
BMI 25-30 (overweight)	15%
BMI > 30 (obese)	2%
No data	19%

teristics: 40% female, 3% Hispanic, 3% Asian, 1% black, and 1% Native American. The mean age was 24 years, with only 3% over 35 years.

Information on risk factors is presented in Table 1. Of the students who had ever smoked, 45% reported that their siblings smoked and 49% reported their parents smoked. A history of CHD, PVD or stroke in a parent or sibling was present for 11% of the students. Smoking history, physical activity, cholesterol levels, and stress levels were not significantly different in students with a family history of CHD, PVD, or stroke. Four percent of students (n=20) had a diagnosis of high blood pressure, 1% (n=3) reported having diabetes and only 1 student reported having angina.

The nutritional intake of the students are reported in Table 2. Calories are reported by sex because of differences in recommended calories for men and women. Student stress was rated using a 5-point scale with 0 indicating low and 5 indicating very high. The mean reported stress level was 2.4 (SD=1.0), with 10% choosing 4 and only 1% choosing 5. Thirty-two percent of students indicated that their stress had increased in the past year.

Table 2. - Nutritional intake (by sex).

	Women (n=305)		Men (n=206)	
	Mean	*St.Dev*	*Mean*	*St. Dev*
Total calories	1784	581	2408	754
% Total calories = fat	32	7	33	7
% Total calories saturated fat	10	3	11	3
% With saturated fat > 10% (of all calories)	43		49	
% With total fat > 30% (of all calories)	49		49	

Discussion

This study found that most UW medical students report health habits consistent with national recommendations and have low risk biophysical profiles. Students reported seatbelt use more often than the general population, indicated that they rarely smoke, are much more likely to be physically active, and less likely to be overweight. Students' mean intake of fat and saturated fat is lower than the state or national averages.[1,2]

While these medical students generally report healthy behaviors, there are still are areas of concern. Smoking is uncommon, but it is disturbing that any future physician is actively smoking. Nearly half consume more fat than the 30% of calories that is recommended. In addition, 1 of 3 students are not reaching recommended exercise frequencies, 1 of 5 has a high blood cholesterol, and 1 of 5 do not regularly use a seatbelt. The screening identified some students with risk significant enough to require follow-up and treatment. Most of these students were unaware of their risk and were referred to their physicians. This data is limited by the response rate, the single measurement, and the self-report nature of the survey and nutritional assessment. Not all students completed all portions of the study, and students who did not participate may have had less positive health habits.

Studies have consistently reported that physicians who have positive health habits are more likely to report counseling patients for healthy lifestyles and that this relationship is behavior specific.[4,6] The health habits described here are better than those reported in a 1990 physician survey in which 4% of physicians smoked, 39% reported regular exercise, 13% reported not using seat belts, and 7% reported "drinking too much."[3] The positive health habits of these students increases the likelihood that future Wisconsin physicians will have positive attitudes toward health behaviors and counsel their patients about lifestyle.

In addition to identifying student health habits, the medical student screening was very useful for teaching clinical preventive medicine. A summary of the student data is used for presenting concepts of population statistics such as normal distributions, cutpoints for risk, and more. Students enjoy comparing themselves to class means and making class-to-class comparisons, which increases interest in the epidemiology and statistical concepts being presented.

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Summary of 1995 Medicare Part B changes

Anne Bicha, SMS policy analyst, and Tamara Larson, SMS Medicare Part B consultant

The following changes are summarized from the *Federal Register*, Dec 8, 1994.

Comments

HCFA applied a uniform adjustment factor of -1.1% to all RVUs to achieve budget neutrality. Adjustments to RVUs may not cause total fee schedule payments to differ by more than $20 million from what they would have been had the adjustments not been made, by federal statute (there is a $20 million tolerance).

HCFA determined that, due to new procedure codes or refinements of existing procedure codes($35 million), the net increases for projected expenditures in calendar year 1995 would have been approximately $385 million.

1995 conversion factors

The 1995 conversion factor updated result from a combination of the default formula, as well as a reduction of 2.7 percentage points for nonprimary care services, as mandated by provisions in OBRA '93. The 1995 conversion factor updated and conversion factors are based on a Medicare economic index.

Update	Service	1995 CF
12.2%	Surgical Services	$39.447
7.9%	Primary Care	$36.382
5.2%	Other Services	$34.616

1995 prformance standards (MVPS)

Surgical services	9.2%
Primary care	13.8%
Other services	4.4%

Anesthesia associated with surgical services is included in the MVPS definition of surgical services.

Payment policy revisions

Geographical practice cost indices changes (GPCIs).

- The statute requires that the GPCIs be reviewed and, if necessary, revised at least every 3 years. The first review is required by 1995. The law also required that only half of any revision be implemented in the first year if more than 1 year has lapsed since the last GPCI revision.
- The revised GPCIs will be phased in over 2 years, with half of the overall adjustment effective 1995.
- The GPCIs were updated to reflect more current data for physician work, employee wages, market rentals and malpractice insurance premiums.
- The final revised GPCIs for 1995 and 1996 can be found in Addenda D and E respectively, of this final rule. The GPCIs are unchanged from those previously published in the June 1994 proposed rule.

Payment area (locality) change. HCFA has previously announced that it plans to review the current payment locality structure for possible comprehensive changes in 1996. In the interim, HCFA will consider only requests for converting states from multiple localities to a single statewide locality. The state must show "overwhelming support" from physicians who would lose under the change, as well as those who would win. Effective Jan 1, 1995, Iowa will be converted to a statewide payment area.

Refinement of proposed RVUs. In the June 1994 proposed rule, HCFA proposed physician work RVUs forapproximately 100 carrier-priced and non-Medicare CPT codes. This section discussed recommendations received on these codes and the 1995 work RVUs for codes that were changed.

Separate payment for physician care plan oversight services. As of Jan 1, 1995, HCFA will allow separate payment for physician care plan oversight services under the following conditions:

- the services are furnished to beneficiaries receiving Medicare-covered home health and hospice services;
- the physician has furnished a service requiring a face-to-face encounter with the patient in the 6 months before the first billing for the service; NS
- the physician does not have a significant financial relationship with the home health agency, is not the medical director or employee of the hospice, and does not provide services under an arrangement with the hospice.

If the above conditions are met, HCFA will do the following:

- allow payment to one physician per month for recurrent physician oversight supervision of therapy involving 30 or more minutes of the physician's time per month;
- allow payment for care plan oversight to a physician providing postsurgical care during the postoperative period only if the care plan oversight is

Continued on next page

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documented to be unrelated to the surgery;

- allow payment during the 30 days following discharge provided that the other conditions for payment are met;
- allow payment under CPT code 99375 in accordance with the above rules (That is, for Medicare purposes, CPT code 99375 refers only to the services furnished to beneficiaries receiving Medicare-covered home health and hospice services requiring 30 or more minutes per month. HCFA will not make additional payment for services beyond 60 minutes, and they will consider CPT code 99376 bundled for Medicare purposes.); and
- base 1995 payment on 1.61 total RVUs (1.06 work RVUs, 0.51 practice expense RVUs, and 0.04 malpractice expense RVUs); the same as the 1995 payment for CPT code 99238.

Payment for multiple surgical procedures. This policy affects payment for multiple surgical procedures performed on the same patient, on the same day, by the same surgeon. The highest valued procedure will be paid the lesser of the actual charge or 100% of the fee schedule amount and the second highest valued procedure at 50%. The third to fifth procedures will now be reimbursed at 50%, as well (previously reimbursed at 25%).

Surgical procedures beyond the fifth procedure will continue to be priced by Medicare carriers "by report" based on documentation of the services furnished. HCFA will rescale RVUs for all services to ensure budget neutrality. HCFA will continue its current payment policy for bilateral surgical procedures.

Application of site-of-service payment differential. In the June 1994 proposed rule, HCFA proposed to update the list of procedures subject to the site-of-service payment differential using 1993 data, to be effective for services furnished beginning Jan 1, 1995. To avert concern about the statistical validity of the data for low-volume procedures, HCFA will exclude any procedure performed fewer than 100 times annually. If the procedure code is part of a "family" of codes that is otherwise on the site-of-service payment differential list, HCFA will include it even if the volume is less than the 100-procedure threshold. (The previous list excluded all procedures with volumes less than 1,000 in 1989).

In the November 1994 final rule, HCFA agreed that the site-of-service limitation should not be applied to services that were on the list of approved procedures for ambulatory surgical centers (ASCs). Therefore, HCFA proposed to add to the list of services subject to the site-of-service payment differential, codes that they had proposed for removal from the list of approved ASC procedures (Dec 14, 1993, *Federal Register*).

The site-of-service list for 1995 appears in Addendum F of this final rule. All additions to the list are identified by an asterisk.

Bundled services. For generation and interpretation of automated data (CPT codes 78890 and 78891), HCFA will assign a "B" status indicator. Payment for these services will be bundled into payments for the primary procedure. HCFA will redistribute the RVUs associated with CPT codes 78890 and 78891 across all other codes in the nuclear medicine section of the CPT manual (CPT codes 78000 though 78999).

For noninvasive ear or pulse oximetry (CPT code 94760), HCFA has decided to continue to allow separate payment under the physician fee schedule.

RVUs for doppler echocardiography. Effective Jan 1, 1995, HCFA will increase the practice expense and malpractice expense RVU of the technical compo-

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nent of CPT code 93325 and decrease the practice expense RVUs of the professional component of the code.

Nuclear medicine. Based on recommendations from the American College of Nuclear Physicians and the Society of Nuclear Medicine, HCFA has proposed, effective Jan 1, 1995, that CPT modifier 51 for multiple procedures be used when it is necessary to perform a whole body plannar study before a SPECT study is performed, both to determine of tomography is needed and to deduce the region to be selectively imaged. This would result in full fee schedule payment for the procedure with the highest payment level and a 50% payment for the second procedure.

End-stage renal disease (ESRD). HCFA will bundle payment for selected evaluation and management services. HCFA will bundle payment for subsequent hospital visits (CPT codes 99231 through 99233) and follow-up inpatient consultations (CPT codes 99261 through 99263) into the fee schedule amounts for inpatient dialysis (CPT codes 90935 through 90947). Carriers will be instructed not to pay a physician for both dialysis and a subsequent hospital visit or a follow-up inpatient consultation on the same date of service. HCFA will allow separate billing and payment for an initial hospital visit (CPT codes 99221-99223), an initial inpatient consultation (CPT codes 99251 through 99255), and a hospital discharge service (CPT code 99238) when billed on the same date as an inpatient dialysis service (CPT codes 90935 through 90947). HCFA will continue to prohibit more than one inpatient dialysis service per date.

HCFA will pay for CPT codes 90918 through 90921 under the Medicare physician fee schedule for services performed on or after Jan 1, 1995. (In the past these codes were reimbursed on "inherent reasonableness"). In addition, HCFA will pay for CPT code 90922. This will be implemented in a budget neutral manner and will apply the nonsurgical update to these codes. HCFA will transition payment to the fee schedule over 2 years--50% fee schedule and 50% historical payment in 1995, and the full fee schedule amount in 1996.

Therapeutic apheresis. HCFA will continue to allow payment for physician work RVUs for therapeutic apheresis under part B in the hospital and nonhospital settings. HCFA will not, however, permit payment for both therapeutic apheresis and certain evaluation and management codes on the same date. Specifically, HCFA will not allow separate payment for CPT codes 99211-99215, 99231-99233 and 99261-

Continued on page 50

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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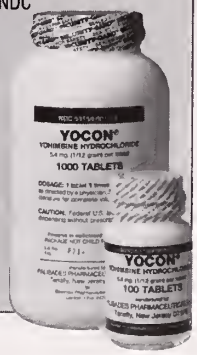

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3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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99263 on the same date that CPT code 36520 (therapeutic apheresis) is provided. The physician may choose to bill for the appropriate evaluation and management code indicating the level of services provided rather than billing for the therapeutic apheresis services.

Separate payment is allowed for physician service furnished to establish the required vascular access if performed by the physician and if the criteria for payment under the appropriate CPT code are satisfied. HCFA will allow separate billing for CPT codes 99221-99223, 99241-99235 and 99251-99255 and 99238 when billed on the same date as CPT code 36250.

This policy will be implemented in a budget neutral manner.

Payment for antigens

As a result of changes made in OBRA '93, effective for services furnished on or after Jan 1, 1995, antigenservices must be paid for under the physician fee schedule. In the final rule, HCFA announced that it will delete the J codes (level 2 HCPCS codes) for antigen services and no longer recognize the complete service codes (CPT codes 95120-95134). Physicians may bill only CPT codes 95144-95149, 95165, and 95170 representing the antigen extract itself and the physician's professional service in creating the extract. HCFA accepted the RVU recommendations for these codes submitted by the Joint Council on Allergy and Immunology as listed in the June 1994 Proposed Rule.

In addition, HCFA stated that it will request a CPT change, effective Jan 1, 1996, so that the language describing the extract or extract preparation codes clearly permits their use by allergists who use treatment boards. A change in the descriptor for the single dose vial code (CPT code 95144) will also be sought to reflect that it is a vial being injected by a physician other than the one who prepared the antigen.❖

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Physician briefs

***Peggy Abel, MD,** internal medicine, has joined the staff of Rhinelander Medical Center. She earned her medical degree from the University of Texas Medical Branch, Galveston, and completed her internship and residency at the University of Texas, Houston.

***Abdul Wajid Chaudhry, MD,** has recently joined the team of doctors at the Two Rivers Clinic, specializing in internal medicine. A native of Lahore, Pakistan, Chaudhry achieved his medical degree from Allama Igbal Medical College in Lahore in 1983. He served his residency for medicine and surgery at Services Hospital, Pakistan. He then completed the Internal Medicine Residency Training Program at St. Luke's Hospital, Washington University, St. Louis, Mo.

***Jole Cler, MD,** orthopedic surgeon, joined the Waupun Memorial Hospital staff this past summer. He received his medical degree from the University of Illinois and did orthopedic training at McLaren Medical Center in Flint, Michigan.

Robert Eckerstorfer, MD, has joined the Midelfort Clinic as a podiatrist. He received his training in podiatry at the University of Osteopathic Medicine Health Sciences, College of Podiatric Medicine and Surgery in Des Moines, Iowa. He is board-qualified with the American Board of Podiatric Surgery and is a member of the American Podiatric Medical Association.

Wayne Evans, MD, has been appointed assistant professor of ob/gyn at the Milwaukee Clinical Campus of the UW Medical School at Sinai Samaritan Medical Center.

***Robert K. Gleeson, MD,** has been promoted to vice president, medical director of the Northwestern Mutual Life Insurance Company, Milwaukee. Dr Gleeson joined Northwestern as an assistant medical director in 1981 and has been a medical director since 1988. He re-

Continued on next page

SMS plans to file amicus brief on behalf of Wisconsin physicians

The SMS Board of Directors approved the filing of an amicus (friend of the court) brief in *Austin v. Mercy Health System*. In 1994, the board of Mercy Hospital of Janesville adopted a policy restricting ICU and SCU clinical privileges to physicians who meet the hospital's new standards for specialists and intensive and special care case management. As a result, a number of physicians who previously had ICU and SCU privileges have lost those privileges.

Those physicians sued the hospital, alleging that the new policy violated several medical staff bylaw provisions, including the fair hearing plan. The trial court, however, granted the defandant's motion for summary judgment and dismissed the case prior to trial, holding that the bylaws generally do not constitute a contract and that they do not limit the ultimate authority of the board to set policy. It also held that the fair hearing plan provisions apply only when physicians lose privileges on an individual basis, rather than when they are lost as a result of a generally applicable change in policy. The plaintiff physicians are appealing that decision.❖

Continued from preceding page
ceived his BSM degree at the University of South Dakota School of Medicine, Vermillion, and in 1975, he graduated from Rush Medical College, Chicago.

Craig T. January, MD, PhD, has been named head of cardiology at the University of Wisconsin Medical School and UW Hospital and Clinics. He is a nationally recognized physician-scientist who has dedicated much of his career to researching faulty heart rhythms. Dr January is a graduate of the University of Iowa, where he received his medical degree and doctorate in physiology and biophysics.

Hazem Mahmoud, MD, a pediatric oncologist, has been appointed associate professor of pediatrics at the Medical College of Wisconsin. Prior to his appointment, he served as associate professor of pediatrics at St. Jude Children's Research Hospital in Memphis. He practices at Children's Hospital of Wisconsin, and conducts research at the Midwest Athletes Against Childhood Cancer Fund Research Center. Dr Mahmoud served a fellowship in hematology/oncology at St. Jude from 1986 to 1989. His earlier training includes a fellowship in pediatric hematology/oncology at Memorial Sloan-Ketterung Career institute in New York, a medical fellowship in pediatrics at the University of Minnesota, an oncology fellowship at Institute Gustave Roussy, Villejuif in Paris, France, and a clinical assistantship in oncologyat the Hospital for Sick Children, Great Ormond, London, Great Britain in 1983.

***Judith Pagano, MD,** an ob/gyn at the Rhinelander Medical Center, is the recipient of the 1994 Juliette Low Woman of Distinction award, from the Birch Trails Girl Scout Council. She has been active in community education programs, and was instrumental in organizing the Northwoods Action Against AIDS Group. She earned her medical degree from the University of Michigan and completed her residency there in 1974.

***Anthony J. Racki, MD,** an internal medicine specialist with more than 17 years experience, began his practice with the Community Health Network Internal Medicine Clinic, Berlin Memorial Hospital,in early November. He served as an assistant professor in clinical medicine at the University of Southern California for the past 16 years. Dr Racki graduated from the University of Illinois College of Pharmacy and the University of Illinois School of Medicine before completing his residency at the USC Medical Center in Los Angeles, California.

***John Reidell, MD,** is the new general surgeon at the Chippewa Valley Area Hospital. He comes from State College, Pennsylvania, where he was a surgeon for twenty-two years. He attended Penn State and Hahnomen Universities for his undergraduate and graduate studies and interned at a hospital in Omaha, Nebraska.

***Daniel Rosler, MD,** has joined Neurological and Rehabilitation Clinic, SC, Milwaukee. He completed his residency at Harbor Hospital Center in Baltimore, specializing in the diagnosis and treatment of arthritis and other joint-related diseases.

Ilan I. Shapiro, MD, an orthopedist, has joined LaSalle Clinic. He comes from Hudson Valley Orthopedics in Hudson, NY. Dr Shapiro received his medical degree from the UW Medical School in Madison. He completed his internship in general surgery at the UW Hospital and Clinics and Middleton, Va. He served an orthopedic residency and fellowship at the Hospital for Joint Diseases in New York.

Floyd Shewmake, Jr., MD, has joined the Kenosha Hospital and Medical Center's Clinical Practice Division, which provides physician services through the hospital's clinic, Kenosha Medical Center Clinic. He began practicing internal medicine and gastroenterology in Kenosha in 1978. He graduated from Rush Medical College, Chicago, and completed his residency in internal medicine and a fellowship in digestive diseases at Presbyterian-St. Luke's Hospital, Chicago.

***Russell Sudbury, MD,** has joined the Tomahawk Medical Center. He earned his medical degree from the University of Illinois College of Medicine, Chicago, Illinois, in 1987. He completed his residency at the UW Department of FamilyMedicine in Eau Claire and began private practice at Red Cedar Clinic in Menomonie, Wis. He has also served as a part-time emergency room physician at Luther Hospital, Eau Claire.

***John D. Wilson, MD,** has joined LaSalle Clinic. He is a pulmonologist who also provides full-time inpatient care at Mercy Medical Center.

***Virginia Kost Wilson, MD,** has joined LaSalle Clinic and is seeing patients from the Koeller Street offices. She is a rheumatologist.✦

County society news

Clark. The Clark County Medical Society approved membership for Milton T. Fong, MD.

Dane. The following physicians have been approved for membership in the Dane County Medical Society: Bonnie Berger-Durnbaugh, MD; Russell Dixon, MD; Anne Eglash, MD; Quentin Gabor, MD; James Gallagher, MD; Robin Gavelin, MD; Jennifer Goedken, MD; Robert Kimmel, MD; Sara Koscielski, MD; Douglas Laube, MD; Jennifer Lisowe, MD; Jane Mahoney, MD; Nola Niccum, MD; Kathy Noordsij, MD; Stephen Nychay, MD; Barbara O'Connell, MD; Thomas Pintar, MD; and Darrell Smith, MD.

Door. The Door Kewaunee County Medical Society approved membership for Fredy Toiber, MD,at their October meeting.

Iowa. Kathryn L. Dalsing, MD, has been approved for membership in the Iowa County Medical Society.

La Crosse. Michael J. Keogh, MD, was elected to membership in the La Crosse County Medical Society at the November meeting.

Marathon. The Marathon County Medical Society approved membership for Mark Thomas Szmanda, MD.

Milwaukee. The following physicians were elected to membership in the Medical Society of Milwaukee County: Michael J. Anderson, MD; Ulrik T. Blaschke, MD; Anthony A. Buechler, MD; Michael P. Byrne, MD; Anne K. Chetty, MD; Karen E. Dobbs, MD; Bruce E. Dunn, MD; Linda F. Fikes, MD; Thomas J. Goblirsch, MD; Jeffrey D. Hosenpud, MD; Pierre Kamguia, MD; Jane M. Kotchen, MD; Edith A. McFadden, MD; Steven Keiji Nakata, MD; Geoffrey Chimbara Nkwazi, MD; William Basil Potos, MD; Navtej S. Purewal, MD; Michele Reyes-Clausen, DO; Bernard B. Rhomberg, MD; Lee Hunter Riley, III, MD; Mark A. Rosen, MD; Richard Rusch, MD; Evan K. Saunders, MD; David I. Stein, MD; Nathan M. Szajnberg, MD; Benjamin J. Teitelbaum, MD; James S. Tweddell, MD; Orlando Ernesto Alvarez, MD; Angelina G. Ausban, MD; Karl E. Baum, MD; Neal D. Bhatia, MD; Karen A. Blindauer, MD; Christian Bratu, MD; Rachael M. Carinhas, MD; Kathleen K. Christians, MD; Mark A. Coppes, MD; Kristine T. Danner, MD; Nancy

Continued on next page

Notice to members of proposed constitutional amendment

THIS NOTICE IS GIVEN to SMS members, pursuant to Article XIII of the SMS Constitution, of the following proposed constitutional amendment introduced at the 1994 SMS annual meeting of the House of Delegates. This amendment may be taken up as old business at the second session of the 1995 SMS annual meeting of the House of Delegates.

Article V, (2) be amended to read:
(2)one delegate representing each specialty section of the Society, and one or more delegates representing the medical student special section, organized under the Bylaws,

Chapter XI, Sec 5 be amended to read:
Sec 5.Each section, except the medical student special section, shall elect a delegate and an alternate to the House of Delegates. The term shall be for two calendar years without limitation on number of terms.

Chapter XI, a new Sec 6 be added to read:
Sec 6.There shall be a special section for medical student members of the Society which shall be entitled to elect one delegate and one alternate to the House of Delegates for each forty candidate members or majority fraction thereof in this Society determined as of the close of the calendar year preceding the first session of the House of Delegates Annual Meeting, provided, however, that this section shall be entitled to at least one delegate and one alternate. The term shall be for one calendar year without limitation on number of terms.

Chapter XI, Sec 6 be renumbered to read:
Sec 67.The Specialty sections of the Society shall be considered an integral part of the working committee structure of the Society as outlined in Chapter VI of these Bylaws.❖

Continued from preceding page
L. Dovin, MD; Curtis A. Erickson, MD; Jerry C. Evans, MD; Marie G. Ferber, MD; Patrick M. Gardner, MD; Nancy S. Ghanayem, MD; Janet B. Goldman, MD; Kelly E. Guglielmi, MD; Elizabeth R. Hagen, MD; Patricia J. Hantsch, MD; David J. Hasler, MD; Philip D. Isherwood, MD; Amin R. Khan, MD; Shahrokh C. Khani, MD; Moon Ja Kim, MD; Aleksandr Krumm, MD; Simon Kingfai Law, MD; Barbara D. Loris, MD; Jennifer E. Macgaffey Thurston, MD; Thomas A. Mallisee, MD; Scott L. Marsan, MD; Amy Jo Miller-McCarthy, MD; Robert E. Nakken, MD; Niraj Nijhawan, MD; Richard L. Pepelea, Jr., MD; Charles D. Pratt, MD; Rowena C. Punzalan, MD; Eleia J. Serrano Reyes, MD; Winston D. Ryan, MD; Laura K. Schille, MD; Inder Pal Singh, MD; Kathleen A. Shallow, MD; Kenneth E. Sparr, MD; Robin Nowbahare Stan, MD; Jay K. Gusler, MD; Rana T. Tan, MD; William M. Tang, MD; Brad C. White, MD; Edith M. Wiesinger, MD; Kendell C. Wilske, MD; Stuart J. Wong, MD; Abutaher M. Yahia, MD; Karen L. Zorek, MD; and Charles J. Rainey, MD.

Wood. The Wood County Medical Society met on November 17, 1994, at the VillageHearth, in Hewitt. Gurinder Sandhu, MD, was accepted as a new member.

Oconto. Peter M. Sutherland, MD, has been approved for membership in the Oconto County Medical Society.

Outagamie. Kenneth J. Bruder, MD, has been approved for membership in the Outagamie County Medical Society.

Vernon. The Vernon County Medical Society approved membership for Brian K. Woody, MD, at their November meeting.

Washington. The Washington County Medical Society approved membership for David G. Benzer, DO; and David P. Imse, MD.

Waukesha. The following physicians were approved for membership in the Waukesha County Medical Society: Patricia A. Barwig, MD; Charles J. Engel, MD; Jill P. Wohlfeil, MD; Sandra G. Amadon, MD; James E. Dall, MD; and Michael J. Chambliss, MD.◆

Republicans control Legislature; two doctors serving in Assembly

FOR THE FIRST TIME in 25 years, Republicans have gained a majority in the state Assembly. Wisconsin will have two physicians serving in the state Assembly: Frank Urban, MD, (R-Brookfield) and Sheldon Wasserman, MD (D-Milwaukee). WISPAC-endorsed Assembly candidates did very well; only three lost their elections. The Republicans also retained a majority in the state Senate. All of the WISPAC-endorsed Senators and candidates were elected to 4-year terms. Both houses have established their leadership teams for the 1995-1997 legislative session:

Assembly leadership

- Speaker David Prosser (R-Appleton);
- Majority Leader Scott Jensen (R-Town of Brookfield);
- Assistant Majority Leader Judy Klusman (R-Oshkosh);
- Speaker Pro Tempore Steve Freese (R-Dodgeville);
- Caucus Chair Mark Green (R-Green Bay);
- Minority Leader Walter Kunicki (D-Milwaukee);
- Assistant Minority Leader Marlin Schneider (D-Wisconsin Rapids); and
- Caucus Chair Rosemary Potter (D- Milwaukee).

Senate leadership

- Majority Leader Mike Ellis (R- Neenah);
- Assistant. Majority Leader Margaret Farrow (R-Elm Grove);
- President Brian Rude (R-Coon Valley);
- President Pro Tempore Alan Lasee (R-DePere);
- Caucus Chair George Petak (R-Racine);
- Minority Leader Bob Jauch (D-Poplar);
- Assistant Minority Leader Fred Risser (D-Madison); and
- Caucus Chair Rod Moen (D-Whitehall).◆

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The individuals and organizations named below made contributions to the Charitable, Educational and Scientific Foundation from October-December 1994.

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The individuals named below made contributions to the Charitable, Educational and Scientific Foundation for the Fort Crawford Medical Museum Capital Improvement Fund.

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In Memoriam
In loving memory of those individuals who will grace our paths forever.

Reuben H. Bitter, MD
Frederick A. Brei, MD
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William C. Janssen, MD
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Albert Kniaz, MD
James F. McDermott, MD
John R. Nickelsen, MD
Lester J. Olson, MD
Mather Pfeiffenberger, MD
Charles C. Wallace, MD

The individuals named below made contributions to the Charitable, Educational and Scientific Foundation through the SMS membership dues statement from September - November 1994.

Continued on next page

AMA seeks reports of insurance carriers making inaccurate claims

Some insurance carriers in Wisconsin who have purchased the GMIS CPT-4 Editing Software for unbundling edits have been inappropriately rejecting certain CPT-4 codes as included in other services. A number of physician offices have called the SMS and reported that the insurance carriers have been claiming the GMIS software was written and sponsored by the AMA. According to the AMA, this software was not written or sponsored by the AMA. The AMA states GMIS purchased the CPT-4 book on disc, which does not include any unbundling edits. The AMA would like to hear from all physicians that have been told by the insurance carriers that this is AMA-sponsored software. Please send your letters to the attention of: Celeste Kirschner, Department of Coding and Nomenclature, American Medical Association, 515 N State St, Chicago, IL 606010, before Feb 1, 1995.❖

Continued from preceding page
Jose J. Alba, MD
M. Yusuf Ali, MD
George W. Arndt, MD
Gregory J. Bachhuber, MD
Raymond G. Bachhuber, MD
Sanford Baim, MD
Anthony H. Balcom, MD
James H. Barbour, MD
Ann Bardeen Henschel, MD
James J. Barrock, MD
Jack R. Bartholmai, MD
William B.A.J. Bauer, MD
Victoriano A. Baylon, MD
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Frank H. Belfus, MD
Charles P. Benedict, MD
E. Maxine Bennett, MD
James F. Bigalow, MD
Edward A. Birge, MD
Mark P. Bishop, MD
Robert D. Bjork, MD
Paul A. Boeder, MD
Richard H. Bolt, MD
Frederick Brei, MD
John P. Briody, MD
Richard J. Brown, MD
Thomas H. Browning, MD
Harvey L. Burdick, MD
Eugene E. Burzynski, MD
Brigido C. Calado, MD
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James L. Concannon, MD
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John E. Conway, MD
William A. Crawford, MD
S. Marshall Cushman, Jr., MD
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Stephen P. Delahunt, MD
Gerald J. Derus, MD
John E. Dettmann, MD
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D. Joe Freeman, MD
W. Bruce Fye, MD
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Gustave A. Landmann, MD
John R. Larsen, MD
Paul A. Larson, MD
Carol W. Latorraca, MD
Elmer G. Lehman, MD
Robert H. Lehner, II, MD
Kristie A. Leong, MD
Julies D. Levin, MD
Walter Lewinnek, MD
Russell F. Lewis, MD
Roland R. Liebenow, MD
Patrick F. Limoni, MD
Richard D. Lindgren, MD
William J. Little, Jr., MD
Charles C. Lobeck, MD
Paul W. Loewenstein, MD
Emilio M. Lontok, MD
Albert A. Lorenz, MD
Erwin P. Ludwig, MD
Rolf S. Lulloff, MD
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William J. Madden, MD
Bill L. Maddix, MD
Henry E. Majeski, MD
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James R. Mattson, MD
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Michael J. O'Neill, MD
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Lyle L. Olson, MD
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David W. Ovitt, MD
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Somrat Pakpreo, MD
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David Alan Perry, MD
Edward L. Perry, MD
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Louis R. Pfeiffer, MD
Kenneth G. Pinegar, MD
Er Chang Ping, Jr., MD
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Barry L. Rogers, MD
Roger L. Ruehl, MD
John R. Russell, MD
William T. Russell, MD
Ben F. Rusy, MD
Martin H. Sahs, MD
Arthur C. Sanders, Jr., MD
Herbert F. Sandmire, MD
Jean H. Schott, MD
Joseph P. Schneider, MD
Joseph B. Schrock, Jr., MD
Gerald H. Schroeder, MD
Caryn I. Schulz, MD
Henry S. Schutta, MD
Paschal A. Sciarra, MD
John K. Scott, MD
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Edwin O. Sheldon, Jr., MD
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Richard T. Shore, MD
Stephen G. Sievers, MD
John L. Sims, MD
George E. Skemp, MD
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Steven D. Stenzel, MD
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Richard H. Strassburger, MD
William J. Sullivan, MD
Charles Supapodok, MD
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Menandro V. Tavera, Jr., MD
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Robert G. Wochos, MD
Leonard W. Worman, MD
Randal J. Zabrowski, MD
Raymond C. Zastrow, MD
James F. Zimmer, MD
Ernest J. Zmolek, MD◆

AMA awards

The Wisconsin physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates members of the SMS.

* Breadon, George E.
* Brownell, Caryn E.
* Carroll, Joel P.
* Effenhauser, Manfred
* Gonzalez, Ramon Angelico
* Holden, Richard C.
* Immerman, Steven C.
* Janowak, Michael C.
* Kennedy, Timothy J.
* Klessig, Heidi T.
* Novsam, Ned R.
* Przlomski, Andrew T.
* Rashid, Ikram Ur.
Roth, Donald A.
Schertz, Elizabeth M.
* Vrabec, Michael P.
* Yuska, Kenneth H.◆

The Gift of Life

The children at St. Jude Children's Research Hospital take life one day at a time. At St. Jude, every second counts. The children here are fighting for their lives.

The doctors and researchers at St. Jude are working to defeat the deadly enemy: childhood cancer. Since St. Jude Hospital opened in 1962, it has forged new treatments for childhood cancer and has helped save the lives of thousands of children around the world. But the battle has just begun.

You can join the fight. To find out how you can help, write to St. Jude, P.O. Box 3704, Memphis, Tennessee 38103, or call 1-800-877-5833.

ST. JUDE CHILDREN'S RESEARCH HOSPITAL
Danny Thomas Founder

FAMILY PRACTICE - MINNEAPOLIS: BC/BE Family Practice Physicians needed to join the Family Practice Department of a 385-physician multi-specialty clinic in desirable Twin Cities area. Currently we have positions available at our Shakopee and Prior Lake offices. Salary and benefits are highly competitive. For additional information contact Patrick Moylan at (612) 993-3286 or send CV and letters of inquiry to Physician Recruitment, Park Nicollet Medical Center, 3800 Park Nicollet Blvd., Minneapolis, MN 55416, or FAX (612) 993-2819. 1-2/95

PRIMARY CARE PHYSICIANS AND SUBSPECIALISTS are being sought for a variety of group practices located throughout the upper Midwest and New York State. Choose from metropolitan cities, college towns, popular resort communities or traditional rural destinations. This month, opportunities available for physicians specializing in family practice, internal medicine, pediatrics, occupational medicine, hematology/oncology and nephrology. New opportunities monthly! For all the facts, call (800)243-4353 or write to: Strelcheck and Associates, 10624 North Port Washington Road, Mequon, WI 53092. 1-3/95

INTERNAL MEDICINE AND PRIMARY CARE - WISCONSIN. Excellent opportunity in beautiful Milwaukee suburb at well established small multispecialty clinic. Full partnership after one year. Send CV to Ozaukee Medical Center, 407 N. Main Street, Thiensville, Wisconsin 53092. 1-3/95

NO ASSEMBLY LINES HERE. FPs, IMs and OB/GYNs at North Memorial owned and affiliated clinics don't hand patients off to the next available specialist. Guide your patients through their entire care process at one of the 25 practices in urban or semi-rural Minneapolis locations. Plus, become eligible for $15,000 on start date. Interested BC/BE MDs, call 1-800-275-4790 or fax CV to 612-520-1564. 1,3,5,7,9,11/95

INTERNIST - CHICAGO: 5 BC internists with offices in northeast and northwest Chicago seeking 6th BE/BC internist. Broad clinical practice with teaching available, if desired. Call will be one in every seventh weekend. Modern clinic facility and affiliation with a licensed 500-bed teaching hospital. Excellent guaranteed income plus full benefits. Contact: Charles Matenaer at 800-272-2777, or fax cv to 414-784-0727. 1-2/95

PEDIATRICIAN - BC/BE to join Pediatric Associates in Milwaukee, St. Joseph/Sherman Park community. Competitive salary, generous fringe benefits. Reply to Malke, c/o Pediatric Associates, 4267 W. Fond du Lac Avenue, Milwaukee, WI 53216. 1-6/95

TOMAH. Ambulatory Care. Tomah VA Medical Center seeks a BC/BE family practitioner or general internist with a strong interest in Ambulatory Care/Primary Care to join our staff. Responsibilities include direct patient care. Excellent benefit package includes malpractice protection, 30 days paid vaca-

RATES: 70 cents per word, with a minimum charge of $30 per ad.

BOXED AD RATES: $40 per column inch. *All ads must be prepaid.*

DEADLINE: Copy must be received by the 1st of the month preceding the month of issue; *eg*, copy for the August issue is due July 1.

SEND TO: *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701. FAX:608-283-5401. Classified ads are not taken over the telephone, but questions may be directed to 608-257-6781 or toll-free 1-800-362-9080.

St. Croix Falls, Wisconsin

Community of 2000 seeks additional Family Practitioner. Practice consists of 13 Family Practitioners, 2 Internists, 1 General Surgeon and 1 Orthopedic Surgeon. Many specialists available on a part-time basis. We are attached to a 90-bed hospital with comprehensive service available. We have a stable medical group with pleasant working conditions in a continuous growth mode.

We are 50 miles NE of the Twin Cities. We offer guaranteed first year salary with second year partnership, and excellent fringes including retirement package.

Send detailed CV:
Cathy Kortas
River Valley Medical Center
208 S. Adams Street
St. Croix Falls, WI 54024
(715) 483-3221.

WANTED

FAMILY PRACTITIONER WHO WANTS THE BEST OF BOTH WORLDS

If you are seeking a traditional practice environment and small-town lifestyle, but want the security and stability of a large group practice, THIS COULD BE YOUR IDEAL OPPORTUNITY! One of Wisconsin's largest multi-specialty groups is seeking an additional FP for a growing branch clinic in central Wisconsin. Chain-O-Lakes area offers outstanding outdoor recreation, strong schools, and traditional family values just minutes from Wisconsin's fastest-growing metropolitan area. Professional and rewarding practice setting, shared call coverage, strong specialty network, and excellent compensation package. For details, call Mike Krier at 1-800-243-4353 or write to:

Strelcheck & Associates, Inc.
10624 N. Port Washington Rd.
Mequon, WI 53092

Physicians Exchange

Continued

tion, and annuity plan. Relocation expenses. 173-acre facility includes limited on-station housing. City of 8,000 in a predominantly rural area that offers affordable real estate, good schools. Conveniently located on I-90/94 midway between Milwaukee and Minneapolis. Interested candidates should contact the Associate Chief of Staff for Ambulatory Care (11F), (608) 372-1785, VA Medical Center, 500 East Veterans Street, Tomah, Wisconsin 54660. AA/EOE. 1/95

LOCUM TENENS

Do you need a physician for a temporary assignment?
or
Are you interested in a temporary assignment?

Wisconsin Physicians working in Wisconsin.

Dunhill Physician Search
1-800-334-6407

11-12/94-1/95

PHYSICIAN WANTED

Community Care for the Elderly is looking for a board certified internist or family practitioner with an interest in the care of the elderly. The position offers an opportunity to care for the frail elderly of the community in an adult health care center and clinic. An understanding of the elderly and the ability to work with a multidisciplinary team is needed. The positions available are part-time and full-time practice. Interested individuals should contact:

Mary Gavinski, MD
Medical Director
Community Care for the Elderly
5228 W. Fond du Lac Avenue
Milwaukee, WI 53216
414-536-2110, ext. 239.

1-2/95

A WARM-SPIRITED AND THRIVING TEN PHYSICIAN GROUP invites two board certified/eligible family physicians to join them in a rewarding and professionally stimulating practice at the Family Medical Clinic in charming Amery, Wisconsin. The patient-friendly Family Medical Clinic is adjoined to the newly renovated 36 bed Apple River Hospital. The Amery physicians are affiliated with Minnesota's first integrated service network based in the nearby Twin Cities of Minneapolis and St. Paul. This relationship offers physicians a private-like practice setting with access to immediate specialty consultations, vertically integrated care, research and teaching opportunities, and financial security. The lake sprinkled town of Amery is a well loved home for outdoor enthusiasts and individuals looking for a real sense of community. Please contact Aynsley Smith at: St. Paul-Ramsey Medical Center, 640 Jackson Street, St. Paul, Minnesota 55101-2595 or (612)221-4230. 1/95

JANESVILLE, WISCONSIN, DEAN MEDICAL CENTER, a 300 physician multispecialty group, is actively recruiting additional BE/BC internal medicine physicians to practice at the Riverview Clinic locations in Janesville, Milton and Delavan, Wisconsin. Traditional internal medicine and urgent care practice opportunities are available. Janesville, population 55,000, is a beautiful, family oriented community with excellent schools and abundant recreational activities. Excellent compensation and benefits are provided with employment leading to shareholder status. Send CV

ASSOCIATE MEDICAL DIRECTOR

Employers Health Insurance, a wholly owned subsidiary of EMPHESYS Financial Group is the nation's 10th largest group health insurer. We currently have a challenging and rewarding position available in our Corporate headquarters located in Green Bay for an Associate Medical Director.

The position will be responsible for assisting the Medical Director with strategic planning, and making recommendations for case management to claims and underwriting management.

Requirements include Board Certification in internal medicine or family practice, eligibility for state licensure, and at least 2 years of medical practice experience. Service on a hospital peer review, utilization review, quality assurance committee, or as a Medical Director of an HMO is essential.

Employers Health Insurance offers a challenging work environment along with a competitive salary and flexible benefit package including 401 (k) and profit sharing. Please send resume to: **Human Resources, EMPLOYERS HEALTH INSURANCE, 1100 Employers Blvd., Green Bay, WI 54344.** An equal opportunity employer.

CHILD OR ADULT PSYCHIATRIST

Seeking energetic psychiatrist interested in developing his/her own private practice. Office space adjacent to Lake Michigan in conjunction with one other psychiatrist. Job sharing a possibility. Shared call. Profitable acute care hospital with a dedicated in-patient psych unit. Relocation expenses provided. Picturesque lakeshore community located one hour north of Milwaukee with a 250 slip marina and the highest SAT scores in the state.

Board certified/eligible candidates contact Diana J. Lampsa, MD, (414-683-9500, or Linda K. Moses, RN, Physician Recruiter at Holy Family Memorial Medical Center, Manitowoc, WI (414) 684-2410.

Physicians Exchange

Continued

to Stan Gruhn, MD, Riverview Clinic, PO Box 551, Janesville, WI 53547 or call (608)755-3500. 1-3/95

JANESVILLE, WISCONSIN, URGENT CARE: Riverview Clinic, a division of Dean Medical Center, is actively recruiting an urgent care physician to join its medical staff. We recently increased our compensation package which is based on a 40 hour work week. Total compensation for Year 1 - $108,000.00, Year 2 - $134,642.00 and Year 3 - $135,000.00. We currently have two physicians which staff the clinic from 9:00 AM - 9:00 PM, Monday through Friday and 9:00 AM - 11:30 AM on Saturday and desire to expand the hours of operation until 9:00 PM on Saturday and 1:00 PM - 9:00 PM on Sunday. Our facility is brand new and well equipped with 8 exam rooms, lab and x-ray. Flexible hours are available with an expected total of 30-40 hours per week. Excellent compensation and benefits are provided. For more information contact Scott M. Lindblom, Dean Medical Center, 1808 West Beltline Highway, Madison, WI 53713,(work phone) 1-800-279-9966 or (608)259-5151, FAX (608)259-5294, (home phone) (608)833-7985. 1-3/95

MADISON, WISCONSIN, DEAN MEDICAL CENTER, a 300 physician multispecialty group is seeking additional family physicians to join its 30 member department. Positions are located at our Arcand Park, East Madison and Deerfield Clinic locations. All positions have an excellent call schedule and obstetrics is optional. Madison is the home of the University of Wisconsin with enrollment of over 40,000 students and the state capital. Abundant cultural and recreational opportunities are available year round. Excellent compensation and benefits are provided with employment leading to shareholder status. Fore more information contact Scott M. Lindblom, Dean Business Office, 1808 West Beltline Hwy., P.O. Box 9328, Madison, Wisconsin, 53715-0328, work at 1-800-279-9966, (608)259-5151 or at home (608)833-7985. 1-3/95

PEDIATRICIANS - Private practice options for caliber pediatricians in NORTHWEST CHICAGO suburbs. Diverse caseload; excellent collections. Rewarding financial potential. Contact Rebecca Turley, 1-800-338-7107; Fax 1-414-785-0895. 11/94-1/95

PHYSICIAN ASSISTANT - MILWAUKEE 17-physician primary care group practice comprised of physicians specializing in Internal Medicine, Pediatrics, OB/GYN and Occupational Medicine is seeking Physician Assistants. In-house lab, X-ray, pharmacy, physical and occupational therapy, an optical dispensary and a complete emergency suite. Surgical and subspecialty consultants also see patients in the clinic. Comprehensive benefit package. To learn more, please call Barbara (800)243-4353 or send

MADISON, WI

Family Practice Opportunities

Physicians Plus Medical Group, a multi-specialty group of 225 physicians seeks additional Family Physicians for it's rapidly expanding department. Established and new locations. Large call groups. Full lab and x-ray. Guaranteed salary plus incentives with a full benefits package. Send CV or call collect:

Laurie Glowac
Director, Medical Administration
PHYSICIANS PLUS MEDICAL GROUP, S.C.
345 W. Washington Avenue
Madison, WI 53703
(608)252-8580
FAX: (608)282-8288

Physicians Plus

An Equal Opportunity Employer

Excellent opportunities are currently available for BC/BE physicians in the following areas:

- OB/GYN
- Pediatrics
- Ophthalmology
- Family Practice
- Internal Medicine

Beloit Clinic, S.C. is a 47-physician multispecialty group located adjacent to a modern, progressive, 180-bed hospital. Excellent family environment, 90 miles from Chicago, in Southern-Wisconsin college community of 50,000 plus with good proximity to a variety of cultural and lifestyle amenities. Guaranteed salary with incentive and excellent benefit package.

Send C.V. to:

James F. Ruethling
Administrator
1905 Huebbe Parkway
Beloit, WI 53511
(608) 364-2380

BELOIT CLINIC S.C.

WISCONSIN

Planned Parenthood of Wisconsin (PPW) is seeking a full-time Medical Director certified in OB/GYN or Family Practice. The candidate should be innovative, energetic, visionary, and committed to reproductive choice. The position provides the opportunity for strategic planning, academic and clinical involvement, administrative oversight of medical services, and a public presence in the promotion of reproductive choice and primary health care for women and families.

PPW is the largest Planned Parenthood in the nation providing health and education services statewide to over 102,000 clients in 40 clinics. In addition, PPW offers statewide sexuality education to communities and professionals. PPW also offers an accredited OB/GYN nurse practitioner program. The PPW corporate offices are located in downtown Milwaukee adjacent to Lake Michigan and within a 10 mile radius of two schools of medicine.

PPW offers a competitive salary and fringe benefits. Submit CVs or direct inquiries to Nancy M. Tabor, Senior Vice President Program Services, Planned Parenthood of Wisconsin, 302 N. Jackson St., Milwaukee, WI 53202. (414) 271-8045.

1/95

Physicians Exchange

Continued

CV to: Strelcheck & Associates, Inc., 10624 N. Port Washington Road, Mequon, WI 53092. 12/94-1/95

NATIONWIDE - Opportunities for the following: IM, FP, OB/GYN, PED, ONC, CD, and more. Send CV to Stan Kent, Stan Kent & Associates, P.O. Box 904, Tremont, IL 61568, or call 800-831-5679, FAX 309-925-5842. 1-5/95

MICHIGAN - Opportunity for 1-2 pediatricians in pretty southern Michigan community of 10,000+. Three+ way call; established patient base. Supportive medical staff. Enjoy all the Midwest has to offer - affordable living, low crime, good schools and plenty of recreational options. Beautiful lake area. First year income guarantee in $120,000 range and more! Call Rebecca Turley 1-800-338-7107; Fax 1-414-785-0895. 11/94-1/95

INTERNAL MEDICINE, CARROLL, IOWA - Outstanding professional opportunity for an internal medicine physician in a progressive, safe and clean community of 10,000 located in west central Iowa, 90 miles from Des Moines, Iowa or Omaha, Nebraska. This opportunity is available for either an in practice internal medicine physician, or the internal medicine physician just beginning practice. Excellent schools (Catholic and public), quality hospital featuring a radiation oncology center, dialysis center, and a new 32,000 sq. ft. outpatient addition. Significant income potential available. For more information, call Randy Simmons, Vice President, at 1-800-382-4197 or write St. Anthony Regional Hospital, South Clark Street, Carroll, IA 51401. 11/94-4/95

MILWAUKEE AREA. A rapidly expanding 70 physician multi-specialty clinic seeks BC/BE physicians in the following specialties: family practice, internal medicine, urology, oncology, pediatrics, general surgery and OB/GYN. Competitive salary, excellent fringe benefits. Address inquiries and CV to: Medical Associates Administrator, PO Box 427, Menomonee Falls, WI 53052-0427. 11/94-4/95

WISCONSIN: Family practitioner-Internal medicine needed by a growing practice of a four physician group in a friendly rural community in Northeast Wisconsin near Green Bay. This is an excellent opportunity to join an established organization. Highly competitive salary with benefits. Please contact: Artwich Clinic, Oconto Falls, Wisconsin 54154. 9/94-5/95

GENERAL SURGEON/FAMILY PRACTICE/OB-GYN/INTERNAL MEDICINE to join progressive 13-physician group practice. Rural college town 30 miles from St. Paul, MN. New clinic and new hospital. Contact Robert B. Johnson, MD, River Falls, WI 54022. 715-425-6701. 8/94-1/95

THE WAUSAU MEDICAL CENTER is seeking Board Certified-Eligible individuals in the following specialties: Internal Medicine, Family Medicine, Obstetrics/Gynecology, Occupational Medicine and Urology. Large multi-specialty group located in central Wisconsin. Competitive salary (incentive after first year). Comprehensive benefit package including malpractice insurance, flexible benefit plan and profit sharing. Modern facility located directly across the street from 250-bed acute care facility. The area is ideal for outdoor enthusiasts (including large downhill ski area) with outstanding cultural activities year round. Write or call collect David K. Aughenbaugh, MD, Medical Director, Wausau Medical Center, 2727 Plaza Drive, Wausau, Wisconsin 54401, telephone (715) 847-3235. 2/93;TFN

Medical Meetings - Continuing Medical Education

"A REASON TO HOPE: LINKING DEMENTIA RESEARCH, CARE AND SERVICES IN THE 21ST CENTURY" - April 6-7, 1995, Milwaukee. A national conference highlighting the latest in Alzheimer's disease research, diagnosis and care. Sponsored by UW-Milwaukee, School of Nursing and the Helen Bader Foundation. Fee: $90. Call 414-229-5514 to receive a brochure. 1/95

4TH ANNUAL NEUROLOGY FOR PRIMARY CARE PHYSICIANS. Friday, May 19 - Saturday, May 20, 1995. Landmark Resort and Conference Center, Egg Harbor, Wisconsin (Door County). Contact: Marshfield Clinic, Office of Medical Education, 1000 North Oak Avenue, Marshfield, WI 54449. 1-800-541-2895.

Miscellaneous

Hunting Club

Looking for two partners to join in purchase of private 200 acre hunting club located on Wolf River near Fremont. Property is heavily timbered bottomland with marshes and offers excellent duck and deer hunting. Legal IRA investment because land is in DNR forest program and will generate income when timber is harvested. Minimum $30,000 investment required, (414) 628-3438. TFN 12/94

For Sale

Medical office equipment, exam room furniture - excellent condition, including lab Cell-Dyne 400 for CBC, small instruments, wall mounted BP appartus, etc. For detailed information, call 715-479-4933. 1/95

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Wisconsin Medical Journal instructions to authors

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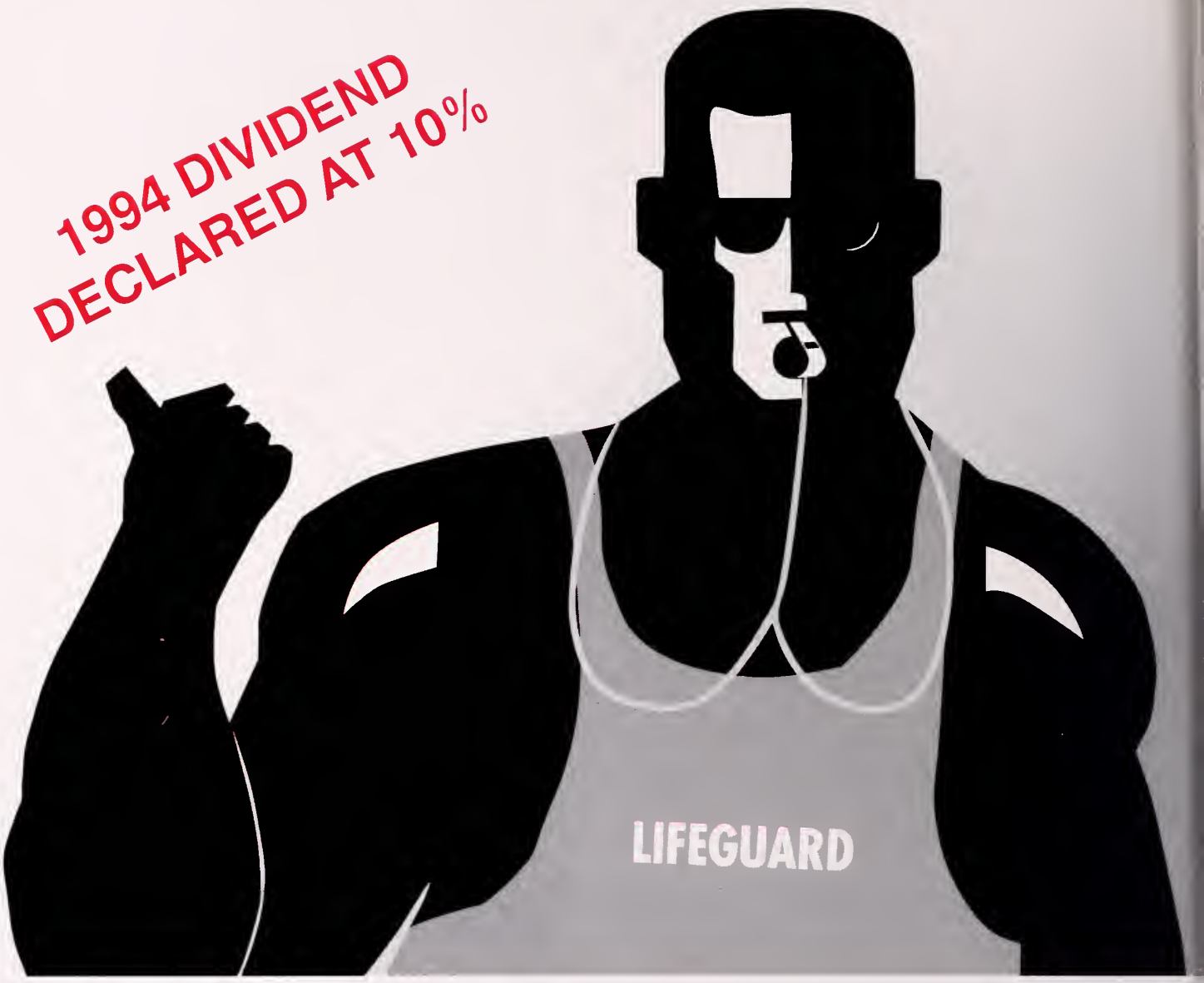

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State Medical Society of Wisconsin

Created by the Territorial Legislature in 1841 and now representing nearly 8,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal*.

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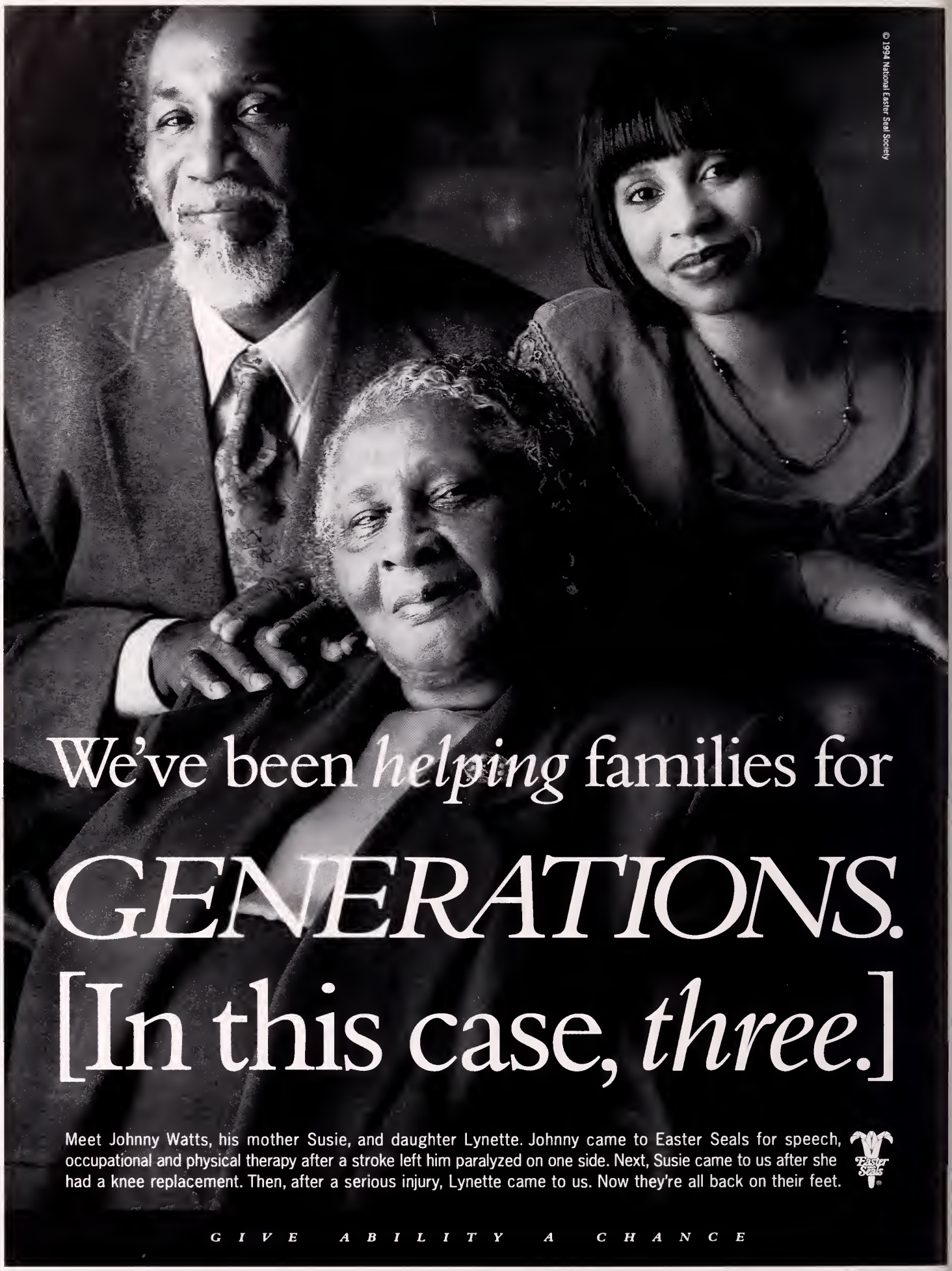
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President's page

Looking ahead through the rear view mirror

When threatened by the uncertainty we call the future, we are tempted to cling to our past. Squinting ahead to a distant horizon that trails off into a blur, we find comfort in the familiarity and the clarity of the road just travelled. At highway speeds however, we soon appreciate a dilemma: if we look back over our shoulder, we risk an accident; if we look ahead, we must content ourselves with a small and confusing glimpse of the past through the rear view mirror. Sadly, our darting glances between the windshield and the view rearward can trap us into a preoccupation with the past and delude us into thinking that our yesterdays are preferable to our todays or tomorrows. Clear eyed reflections on "the good old days" suggest however, that while those old days are gone, they were not necessarily any better than today, at least for physicians (see boxed insert).

A cynic is not merely one who reads bitter lessons from the past; he is one who is prematurely disappointed in the future.

--Sydney J. Harris

Medicine's past is replete with proprietary medical education; profiteering; and "incurable" scourges (eg, polio, syphilis, and tuberculosis). Determined physicians were able to surmount these and other challenges by dedicating themselves to the welfare of patients first. Similar modern challenges (burdensome educational costs; economically driven restructuring of the health care system; and HIV infection and violence) can also be surmounted. As the complexity of medical practice increases, so must the efforts of the State Medical Society to help physicians and their patients survive the evolving system. The SMS has developed a survival guide through its strategic planning process. Informed by membership survey information, several Board meetings, and a weekend retreat, the Strategic Planning Committee has developed, and the Board has

Richard G. Roberts, MD, JD

Continued on next page

approved, a plan to prepare the Society and Wisconsin's physicians for the next century. Details about the plan can be found in this issue of *WMJ*. Included below are some summary comments to whet your appetite.

I have seen the future, and it works.
--*Lincoln Steffens*

The Strategic Planning Committee recommended the following priorities for the SMS over the next 3 years:

1. *Physician and patient advocacy.* Advocacy for Wisconsin's physicians and their patients will be expanded beyond the traditional focus on governmental activities to include the monitoring of managed care and other health system organizations. A mechanism will be developed to respond to and collect information of physician and patient complaints about health care entities.
2. *Communication.* The SMS will enhance its position as *the* source of health care information in Wisconsin, including the use of emerging communication technologies to increase physician awareness and involvement. The use of electronic media (eg, e-mail, computerized databases) to improve the ease of communication will be explored.
3. *Member involvement.* The increasing diversity of SMS members will be addressed through innovative strategies for participation (eg, videoconferencing instead of face-to-face meetings). Efforts will be undertaken to increase the involvement of women, IMG, young, and minority physicians.
4. *Practice management.* Current SMS practice initiatives (eg, coding seminars) will bebetter packaged and targeted to more effectively meet the practice management needs of members. The Society will be seen as the source for practice management assistance.

You cannot step twice into the same river, for other waters are continually flowing in. - -*Heraclitus*

A successful strategic plan depends on a willingness to let go of some old priorities to take on new priorities, based on the ever-changing environment. I have participated in several strategic plans over the years and found them to be painful and protracted exercises in futility that resulted in reports filed somewhere which were never again seen. Participating in this plan was surprisingly enjoyable because I believe it resulted in something important for Wisconsin's physicians. We must let go of our compulsion to constantly glance back at the road behind us; we must concentrate our focus on the road ahead. Our strategic plan will allow us to move forward purposefully and confidently and, perhaps, even enjoy the scenery along the way.❖

Chiefly, state medicine's sourest fruits would seem to be:

1. Lowered morale on the part of the profession;
2. Inadequate service towards the clientele due to bureaucratic red tape, inadequate recompense and inadequate study and diagnosis of individual cases eventuating from a mass clientele;
3. Too much lay control of scientific practice;
4. Too political and too unscientific a control;
5. Too much taxation for results to taxpayers;
6. Government interference with affairs of nature involved to be regimented under human mechanistics;
7. Development of a group of maladies imaginary or of malingering citizens who find it more profitable to ail at the expense of the state than to follow the normal lines of industry;
8. No reduction in death nor increase in birth rate;
9. Analogous ethical debauchery of the apothecaries and loss of profit to them as well as to dentists;
10. General chaos of method and confusion of ideals with no profit except to uninformed lay supervisors and inspectors.

The physicians of the United States will do well in the coming year to study this both from the point of the profession and the public, but also from the public pocketbook, which is after all, only the heart and wealth of the nation.--*Illinois Medical Journal*, 1939❖

EVP report
The iron is hot

THE CAPITOL DOME has seen a flurry of activity these past few weeks, but two events stand out as most significant for physicians. One is tort reform; the other is the governor's budget proposal.

On the first topic--tort reform--I am pleased to report that Mike Kirby, the governmental affairs staff, and a host of highly involved physicians were successful in both passing Assembly Bill 36, which caps non-economic damages in medical malpractice cases at $350,000, and in moving up the timetable for the Senate's consideration of our tort reform package. As of this writing, the Senate Judiciary Committee is expected to take up the bill Feb 22, and the full Senate is expected to vote on the bill March 1.

Let me pause here to tip my metaphorical hat to Assembly Speaker David Prosser (R-Appleton) for providing strong leadership on this issue, and to the 63 other representatives--Republicans and Democrats--who voted to pass this important bill. Please see our related story on page 87 for more details.

A major battle has been won, but the tort war is not over. Your help is still needed. The trial lawyers, of course, are not waving any white flags of surrender, and we expect them to mount significant opposition in the Senate. The governor has told us repeatedly that he will sign whatever bill we can get to his desk, so I expect he will sign the $350,000 cap if it passes. It will be a great day, culminating 10 years of work, when it happens.

The second topic--the governor's budget proposal--has something in it to raise the ire of almost everyone, which is one way of saying it's probably the most innovative and ambitious budget proposal in two decades. For better or for worse, this is nothing short of a proposal to change the fundamental way in which state government operates. The analysts, advocates and opinion writers have been spilling barrels of ink since the budget was introduced on Valentine's Day, and likely will keep it up for some time to come.

So far, the actual bill has not been released, so details are sketchy. But judging from a variety of news reports, there are issues here that are of particular interest to physicians: privatization of the University Hospital in Madison; lowering rates of Medicaid payments for some health care providers; elimination of nursing home care for the "medically needy"; imposition an "assessment" on physicians ($300 per license renewal period, including retired physicians); cuts to the WIC program and assistance to poor disabled people; expansion of MA coverage to nurse-midwifery; establishment of rural medical centers as a category of health care providers requiring licensing and regulation; and the restructuring of the Department of Health and Social Services. We will be watching these issues, and you should be, too, but the physicians of Wisconsin--like all citizens of Wisconsin--should adopt a broad perspective and take in the entire picture when deciding whether to back the governor's proposal.

There is a lot to consider, not only because of the number and significance of the changes proposed, but because of the many "on the other hands" involved. It lowers income taxes for some residents, but raises it for some others. It cuts the property tax, but raises a number of user fees. It shrinks some parts of government, but concentrates enormous power in others. It takes whacks at welfare, but it provides a $2 million bailout to dog tracks. The list could go on for pages. These "on the other hands" keep the pundits happy trading punches, but they also make your careful consideration of the big picture absolutely critical.

Thomas L. Adams, CAE

Think of summer vacations as an analogy (most of us are this time of year!): The kids run down the beach to "say hello" to the lake. They pause a moment to take in the panorama--the beach, the water, the piers, the surrounding cottages and landmarks--then stick their toes in to test the water temperature. In the next instant, they're in up to their necks. Take in the "big picture" of the governor's budget and, once you've tested the water, plunge in. Get involved and stay involved. Big things are happening, and it has been a long time since your individual participation has mattered this much.✦

Letter

The physician's role in assisting patients to end life

To the Editor: Polls reveal that a majority of people believe that patients should have more control in end-of-life decisions, even asking assistance to end life under certain circumstances. Some have questioned why physicians' organizations should be opposed to such freedoms. Physicians have been leaders in advocating the right of a patient to know and to enter into decision making. Has this been just lip service? Could it be that complicated technology has been increasing a gap between the dominant authority and the dependent patient, giving less attention to patients' requests?

As the end-of-life debate increases, it is hoped that physicians will be involved but that pro and con positions will be offered with respect and without fractiousness. It is an absolute that no physician ever, if required to, be involved in anything considered personally to be immoral or unethical. Further, it is an absolute that any assistance in helping a patient to end life would be only by patient request. Many physicians are guided by Hippocratic or religious convictions. Arguments regarding the degree of such devotion to principles are specious and stray from the focus of discussion--how physicians can best help patients.

In medicine, we have prided ourselves on the individualization of our diagnosis and treatment recommendations. In that light, can we rule out that there are some patients who really need more assistance than we are giving them? Yes, Hospice, pastoral ministry, and aggressive pain management services are helpful and appreciated. Yet, there is abundant evidence that there are yet patients who have uncontrolled agonizing, painful courses when there is nothing left but to die.

Most people who are asking for assistance in ending life have never been suicidal as they lived out their lives up to the terminal state. In all the discussion about suicide, we have forgotten the precious word treatment, which may be what a patient wishes from somebody the patient trusts.

Legislators, even physicians, have used the "don't play God" defense, which is questionable, considering the countless number of decisions we make that affect patients' lives. Perhaps the height of "playing God" is to certainty--and then to require the patient to endure a societal-mandated course, unwanted and on somebody else's terms. Life, in a spiritual sense, cannot be defined in a narrow biological sense.

In medical training, I am unaware of any narrow directive simply to preserve life. Our mission has been to listen, to treat, to comfort, to relieve--which usually preserves life. However, when mere preservation poses extreme hardship on a patient and family, then I wonder if we're being faithful to our calling. Somehow, for the healer to tell the family, "It shouldn't be long" seems hollow and without hope.

—Ralph F. Hudson, MD
Eau Claire❖

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Head injuries and domestic violence

To the Editor: We endorse the attempts of Dr Chelmowski and Dr Hamberger to heighten our awareness of the need for screening for domestic violence; however, we feel compelled to comment further on the plight of the patient in your case report.

He provides an excellent example of aggressive behavior following mild traumatic head injury. Affective symptoms following mild head injury commonly include emotional lability, decreased frustration tolerance, depression, irritability, anxiety, and impatience. It is especially important to educate the patient and family regarding the affective symptoms following a mild traumatic head injury.

While post-concussional symptoms are often worsened or perpetuated by psychological factors, it should be remembered that the onset of these symptoms is generally neurologically caused. Animal experiments have shown that after an acute brain injury, a chronic state of neurotransmission deficiency may persist. During this period, agents supplementing neurotransmission may be useful in improving outcome. Specifically, the serotonergic agonists have been shown to work well for problems of emotional liability, irritability, anxiety, and decreased frustration tolerance in the mild brain injury patient.

Other drugs that have been shown to be useful in controlling aggressive behavior in mild brain injury patients include carbamazepine, propranolol, bromocriptine and lithium carbonate.

We recommend that, in addition to referral to a program for men who batter their partners, this patient and others like him should be referred to a local mild head injury outpatient rehabilitation program. If such a program does not exist in your area, then referral to a physiatrist, neurologist or neuropsychologist or psychiatrist who deals with head injury patients would be appropriate.

—Arlene M. Braker, MD
—Mark A. Klingbeil, MD
Milwaukee❖

Soundings
The Falling Leaf

A brightly painted red and green and orange leaf
Picked up by a gentle breeze as it began to fall
Flew up and down across the meadow rising, dipping
Dancing—truly not heading toward the green and beckoning earth.
I knew it no longer was alive. Autumn had come.
The wind had severed the glorious happy leaf from twig and branch.
No source of life—and yet it danced, pirouetting, whirling
Into the distance—beyond sight and knowledge
Over the horizon, still rising. Then descending to the beyond.

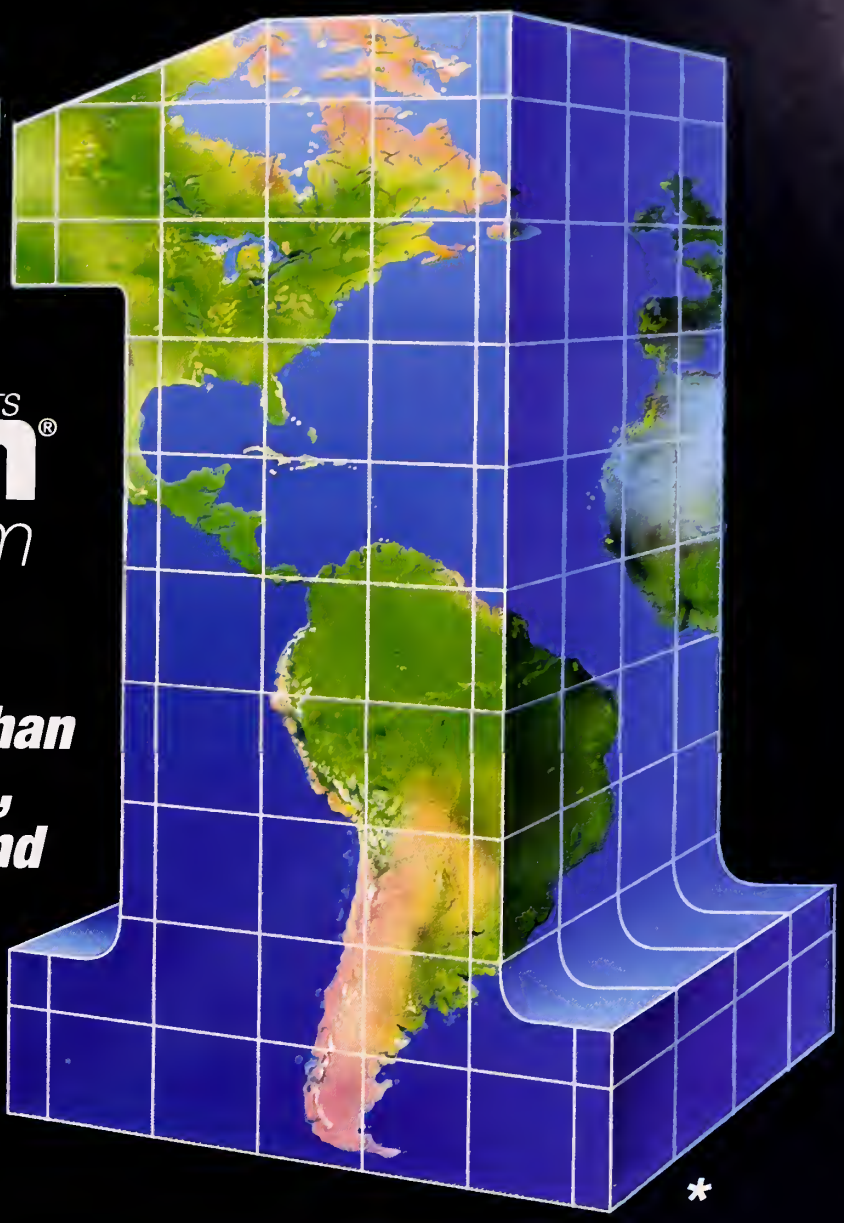
So it was that the young doctor, the earliest day of premature Autumn
Was swept by the Holy breath of God away from twig and branch
He fell and then leaped upward praising and singing
Dancing and falling, rising and dipping, upward - upward
Caught by the wind, going higher, flying outward, sighing.
Over the horizon, away from our sight, away from pain and sorrow.
Like the brightly colored Autumn leaf and yet not earth bound.
Heading joyously not toward earth but toward the new life given -

Given to all who, severed from the branch of earthly life, breathe deeply of the wind of eternity, the everlasting life given to those who love.

—William Standish Reed, MD
Tampa, Fla

As I saw at the cemetery a single leaf fall—not really falling, but dancing in the sunlight on a sad and trying day, the day of the funeral of Dr Chris Wallace, a 46 year old friend who died of melanoma in November in Appleton, Wis.❖

ONCE AGAIN



25·50·75-MG TABLETS

Voltaren®

diclofenac sodium

More prescriptions worldwide in 1992 than Feldene®, Naprosyn®, Relafen®, Lodine®, and Daypro® combined*†

**** Based on number of prescriptions worldwide (IMS MIDAS, 6/93).***

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Please see Brief Summary of Prescribing Information on adjacent page.

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VOLTAREN®

diclofenac sodium
Delayed-Release (enteric-coated) Tablets

CATAFLAM®

diclofenac potassium
Immediate-Release Tablets

Brief Summary (For full Prescribing Information, see Package Insert.)

INDICATIONS AND USAGE

Voltaren Delayed-Release or Cataflam Immediate-Release Tablets are indicated for the acute and chronic treatment of signs and symptoms of rheumatoid arthritis, osteoarthritis, and ankylosing spondylitis. Only Cataflam is indicated for the management of pain and primary dysmenorrhea, when prompt pain relief is desired, because it is formulated to provide earlier plasma concentrations of diclofenac (see CLINICAL PHARMACOLOGY, Pharmacokinetics and Clinical Studies).

CONTRAINDICATIONS

Diclofenac in either formulation (Voltaren or Cataflam) is contraindicated in patients with hypersensitivity to diclofenac. Diclofenac should not be given to patients who have experienced asthma, urticaria, or other allergic-type reactions after taking aspirin or other NSAIDs. Severe, rarely fatal, anaphylactic-like reactions to diclofenac have been reported in such patients.

WARNINGS

Gastrointestinal Effects

Peptic ulceration and gastrointestinal bleeding have been reported in patients receiving diclofenac. Physicians and patients should therefore remain alert for ulceration and bleeding in patients treated chronically with diclofenac even in the absence of previous G.I. tract symptoms. It is recommended that patients be maintained on the lowest dose of diclofenac possible, consistent with achieving a satisfactory therapeutic response.

Risk of G.I. Ulcerations, Bleeding, and Perforation with NSAID Therapy: Serious gastrointestinal toxicity such as bleeding, ulceration, and perforation can occur at any time, with or without warning symptoms, in patients treated chronically with NSAID therapy. Although minor upper gastrointestinal problems, such as dyspepsia, are common, usually developing early in therapy, physicians should remain alert for ulceration and bleeding in patients treated chronically with NSAIDs even in the absence of previous G.I. tract symptoms. In patients observed in clinical trials of several months to 2 years' duration, symptomatic upper G.I. ulcers, gross bleeding, or perforation appear to occur in approximately 1% of patients for 3-6 months, and in about 2%-4% of patients treated for 1 year. Physicians should inform patients about the signs and/or symptoms of serious G.I. toxicity and what steps to take if they occur.

Studies to date have not identified any subset of patients not at risk of developing peptic ulceration and bleeding. Except for a prior history of serious G.I. events and other risk factors known to be associated with peptic ulcer disease, such as alcoholism, smoking, etc., no risk factors (e.g., age, sex) have been associated with increased risk. Elderly or debilitated patients seem to tolerate ulceration or bleeding less well than other individuals, and most spontaneous reports of fatal G.I. events are in this population. Studies to date are inconclusive concerning the relative risk of various NSAIDs in causing such reactions. High doses of any NSAID probably carry a greater risk of these reactions, although controlled clinical trials showing this do not exist in most cases. In considering the use of relatively large doses (within the recommended dosage range), sufficient benefit should be anticipated to offset the potential increased risk of G.I. toxicity.

Hepatic Effects

As with other NSAIDs, elevations of one or more liver tests may occur during diclofenac therapy. These laboratory abnormalities may progress, may remain unchanged, or may be transient with continued therapy. Borderline elevations (i.e., less than 3 times the ULN [=the Upper Limit of the Normal range]), or greater elevations of transaminases occurred in about 15% of diclofenac-treated patients. Of the hepatic enzymes, ALT (SGPT) is the one recommended for the monitoring of liver injury.

In clinical trials, meaningful elevations (i.e., more than 3 times the ULN) of AST (SGOT) (ALT was not measured in all studies) occurred in about 2% of approximately 5700 patients at some time during Voltaren treatment. In a large, open, controlled trial, meaningful elevations of ALT and/or AST occurred in about 4% of 3700 patients treated for 2-6 months, including marked elevations (i.e., more than 8 times the ULN) in about 1% of the 3700 patients. In that open-label study, a higher incidence of borderline (less than 3 times the ULN), moderate (3-8 times the ULN), and marked (>8 times the ULN) elevations of ALT or AST was observed in patients receiving diclofenac when compared to other NSAIDs. Transaminase elevations were seen more frequently in patients with osteoarthritis than in those with rheumatoid arthritis (see ADVERSE REACTIONS).

In addition to the enzyme elevations seen in clinical trials, rare cases of severe hepatic reactions, including jaundice and fatal fulminant hepatitis, have been reported.

Physicians should measure transaminases periodically in patients receiving long-term therapy with diclofenac, because severe hepatotoxicity may develop without a prodrome of distinguishing symptoms. The optimum times for making the first and subsequent transaminase measurements are not known. In the largest U.S. trial (open-label) that involved 3700 patients monitored first at 8 weeks and 1200 patients monitored again at 24 weeks, almost all meaningful elevations in transaminases were detected before patients became symptomatic. In 42 of the 51 patients in all trials who developed marked transaminase elevations, abnormal tests occurred during the first 2 months of therapy with diclofenac. Based on this experience, if diclofenac is used chronically, the first transaminase measurement should be made no later than 8 weeks after the start of diclofenac treatment. As with other NSAIDs, if abnormal liver tests persist or worsen, if clinical signs and/or symptoms consistent with liver disease develop, or if systemic manifestations occur (e.g., eosinophilia, rash, etc.), diclofenac should be discontinued.

To minimize the possibility that hepatic injury will become severe between transaminase measurements, physicians should inform patients of the warning signs and symptoms of hepatotoxicity (e.g., nausea, fatigue, lethargy, pruritus, jaundice, right upper quadrant tenderness, and "flu-like" symptoms), and the appropriate action patients should take if these signs and symptoms appear.

PRECAUTIONS

General

Allergic Reactions: As with other NSAIDs, allergic reactions including anaphylaxis have been reported with diclofenac. Specific allergic manifestations consisting of swelling of eyelids, lips, pharynx, and larynx, urticaria, asthma, and bronchospasm, sometimes with a concomitant fall in blood pressure (severe at times) have been observed in clinical trials and/or the marketing experience with diclofenac. Anaphylaxis has rarely been reported from foreign sources; in U.S. clinical trials with diclofenac in over 6000 patients, 1 case of anaphylaxis was reported. In controlled clinical trials, allergic reactions have been observed at an incidence of 0.5%. These reactions can occur without prior exposure to the drug.

Fluid Retention and Edema: Fluid retention and edema have been observed in some patients taking diclofenac. Therefore, as with other NSAIDs, diclofenac should be used with caution in patients with a history of cardiac decompensation, hypertension, or other conditions predisposing to fluid retention.

Renal Effects: As a class, NSAIDs have been associated with renal papillary necrosis and other abnormal renal pathology in long-term administration to animals. In oral diclofenac studies in animals, some evidence of renal toxicity was noted. Isolated incidents of papillary necrosis were observed in a few animals at high doses (20-120 mg/kg) in several baboon subacute studies. In patients treated with diclofenac, rare cases of interstitial nephritis and papillary necrosis have been reported (see ADVERSE REACTIONS).

A second form of renal toxicity, generally associated with NSAIDs, is seen in patients with conditions leading to a reduction in renal blood flow or blood volume, where renal prostaglandins have a supportive role in the maintenance of renal perfusion. In these patients, administration of an NSAID results in a dose-dependent decrease in prostaglandin synthesis and, secondarily, in a reduction of renal blood flow, which may precipitate overt renal failure. Patients at greatest risk of this reaction are those with impaired renal function, heart failure, liver dysfunction, those taking diuretics, and the elderly. Discontinuation of NSAID therapy is typically followed by recovery to the pretreatment state.

Cases of significant renal failure in patients receiving diclofenac have been reported from marketing experience, but were not observed in over 4000 patients in clinical trials during which serum creatinine and BUN values were followed serially. There were only 11 patients (0.3%) whose serum creatinine and concurrent serum BUN values were greater than 2.0 mg/dL and 40 mg/dL, respectively, while on diclofenac (mean rise in the 11 patients' creatinine 2.3 mg/dL and BUN 28.4 mg/dL).

Since diclofenac metabolites are eliminated primarily by the kidneys, patients with significantly impaired renal function should be more closely monitored than subjects with normal renal function.

Porphyria: The use of diclofenac in patients with hepatic porphyria should be avoided. To date, 1 patient has been described in whom diclofenac probably triggered a clinical attack of porphyria. The postulated mechanism, demonstrated in rats, for causing such attacks by diclofenac, as well as some other NSAIDs, is through stimulation of the porphyrin precursor delta-aminolevulinic acid (ALA).

Information for Patients

Diclofenac, like other drugs of its class, is not free of side effects. The side effects of these drugs can cause discomfort and, rarely, there are more serious side effects, such as gastrointestinal bleeding, and more rarely, liver toxicity (see WARNINGS, Hepatic Effects), which may result in hospitalization and even fatal outcomes.

NSAIDs are often essential agents in the management of arthritis and have a major role in the management of pain, but they also may be commonly employed for conditions that are less serious.

Physicians may wish to discuss with their patients the potential risks (see WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS) and likely benefits of NSAID treatment, particularly when the drugs are used for less serious conditions where treatment without NSAIDs may represent an acceptable alternative to both the patient and physician.

Laboratory Tests

Because serious G.I. tract ulceration and bleeding can occur without warning symptoms, physicians should follow chronically treated patients for the signs and symptoms of ulceration and bleeding and should inform them of the importance of this follow-up (see WARNINGS, *Risk of G.I. Ulcerations, Bleeding, and Perforation with NSAID Therapy*). If diclofenac is used chronically, patients should also be instructed to report any signs and symptoms that might be due to hepatotoxicity of diclofenac, these symptoms may become evident between visits when periodic liver laboratory tests are performed (see WARNINGS, Hepatic Effects).

Drug Interactions

Aspirin: Concomitant administration of diclofenac and aspirin is not recommended because diclofenac is displaced from its binding sites during the concomitant administration of aspirin, resulting in lower plasma concentrations, peak plasma levels, and AUC values.

Anticoagulants: While studies have not shown diclofenac to interact with anticoagulants of the warfarin type, caution should be exercised, nonetheless, since interactions have been seen with other NSAIDs. Because prostaglandins play an important role in hemostasis, and NSAIDs affect platelet function as well, concurrent therapy with all NSAIDs, including diclofenac, and warfarin requires close monitoring of patients to be certain that no change in their anticoagulant dosage is required.

Digoxin, Methotrexate, Cyclosporine: Diclofenac, like other NSAIDs, may affect renal prostaglandins and increase the toxicity of certain drugs. Ingestion of diclofenac may increase serum concentrations of digoxin and methotrexate and increase cyclosporine's nephrotoxicity. Patients who begin taking diclofenac or who increase their diclofenac dose or any other NSAID while taking digoxin, methotrexate, or cyclosporine may develop toxicity characteristics for these drugs. They should be observed closely, particularly if renal function is impaired. In the case of digoxin, serum levels should be monitored.

Lithium: Diclofenac decreases lithium renal clearance and increases lithium plasma levels. In patients taking diclofenac and lithium concomitantly, lithium toxicity may develop.

Oral Hypoglycemics: Diclofenac does not alter glucose metabolism in normal subjects nor does it alter the effects of oral hypoglycemic agents. There are rare reports, however, from marketing experiences of changes in effects of insulin or oral hypoglycemic agents in the presence of diclofenac that necessitated changes in the doses of such agents. Both hypo- and hyperglycemic effects have been reported. A direct causal relationship has not been established, but physicians should consider the possibility that diclofenac may alter a diabetic patient's response to insulin or oral hypoglycemic agents.

Diuretics: Diclofenac and other NSAIDs can inhibit the activity of diuretics. Concomitant treatment with potassium-sparing diuretics may be associated with increased serum potassium levels.

Other Drugs: In small groups of patients (7-10/interaction study), the concomitant administration of azathioprine, gold, chloroquine, D-penicillamine, prednisolone, doxycycline, or digitoxin did not significantly affect the peak levels and AUC values of diclofenac.

Protein Binding

In vitro, diclofenac interferes minimally or not at all with the protein binding of salicylic acid (20% decrease in binding), tolbutamide, prednisolone (10% decrease in binding), or warfarin. Benzylpenicillin, ampicillin, oxacillin, chlortetracycline, doxycycline, cephalothin, erythromycin, and sulfamethoxazole have no influence in vitro on the protein binding of diclofenac in human serum.

Drug/Laboratory Test Interactions

Effect on Blood Coagulation: Diclofenac increases platelet aggregation time but does not affect bleeding time, plasma thrombin clotting time, plasma fibrinogen, or factors V and VII to XII. Statistically significant changes in prothrombin and partial thromboplastin times have been reported in normal volunteers. The mean changes were observed to be less than 1 second in both instances, however, and are unlikely to be clinically important. Diclofenac is a prostaglandin synthetase inhibitor, however, and all drugs that inhibit prostaglandin synthesis interfere with platelet function to some degree, therefore, patients who may be adversely affected by such an action should be carefully observed.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in rats given diclofenac sodium up to 2 mg/kg/day or (12 mg/m²/day approximately the human dose) have revealed no significant increases in tumor incidence. There was a slight increase in benign mammary fibroadenomas in mid-dose-treated (0.5 mg/kg/day or 3 mg/m²/day) female rats (high-dose females had excessive mortality), but the increase was not significant for this common rat tumor. A 2-year carcinogenicity study conducted in mice employing diclofenac sodium at doses up to 0.3 mg/kg/day (0.9 mg/m²/day) in males and 1 mg/kg/day (3 mg/m²/day) in females did not reveal any oncogenic potential. Diclofenac sodium did not show mutagenic activity in in vitro point mutation assays in mammalian (mouse lymphoma) and microbial (yeast, Ames) test systems and was nonmutagenic in several mammalian in vitro and in vivo tests, including dominant lethal and male germinal epithelial chromosomal studies in mice, and nucleus anomaly and chromosomal aberration studies in Chinese hamsters. Diclofenac sodium administered to male and female rats at 4 mg/kg/day (24 mg/m²/day) did not affect fertility.

Teratogenic Effects

There are no adequate and well-controlled studies in pregnant women. Diclofenac should be used during pregnancy only if the benefits to the mother justify the potential risk to the fetus.

Pregnancy Category B: Reproduction studies have been performed in mice given diclofenac sodium (up to 20 mg/kg/day or 60 mg/m²/day) and in rats and rabbits given diclofenac sodium (up to 10 mg/kg/day or 60 mg/m²/day for rats, and 80 mg/m²/day for rabbits), and have revealed no evidence of teratogenicity despite the induction of maternal toxicity and fetal toxicity. In rats, maternally toxic doses were associated with dystocia, prolonged gestation, reduced fetal weights and growth, and reduced fetal survival. Diclofenac has been shown to cross the placental barrier in mice and rats.

Labor and Delivery

The effects of diclofenac on labor and delivery in pregnant women are unknown. Because of the known effects of prostaglandin-inhibiting drugs on the fetal cardiovascular system (closure of ductus arteriosus), use of diclofenac during late pregnancy should be avoided and, as with other nonsteroidal anti-inflammatory drugs, it is possible that diclofenac may inhibit uterine contraction.

Nursing Mothers

Diclofenac has been found in the milk of nursing mothers. As with other drugs that are excreted in milk, diclofenac is not recommended for use in nursing women.

Pediatric Use

Safety and effectiveness of diclofenac in children have not been established.

Geriatric Use

Of the more than 6000 patients treated with diclofenac in U.S. trials, 31% were older than 65 years of age. No overall difference was observed between efficacy, adverse event or pharmacokinetic profiles of older and younger patients. As with any NSAID, the elderly are likely to tolerate adverse reactions less well than younger patients.

ADVERSE REACTIONS

Adverse reaction information is derived from blinded, controlled and open-label clinical trials, as well as worldwide marketing experience. In the description below, rates of more common events represent clinical study results, rarer events are derived principally from marketing experience and publications, and accurate rate estimates are generally not possible.

In a 6-month, double-blind trial comparing Voltaren Delayed-Release Tablets (N=197) vs Cataflam Immediate-Release Tablets (N=196) vs ibuprofen (N=197), adverse reactions were similar in nature and frequency. In 718 patients treated for shorter periods, i.e., 2 weeks or less, with *Cataflam Immediate-Release Tablets*, adverse reactions were reported one-half to one-tenth as frequently as by patients treated for longer periods.

The incidence of common adverse reactions (greater than 1%) is based upon controlled clinical trials in 1543 patients treated up to 13 weeks with *Voltaren Delayed-Release Tablets*. By far the most common adverse effects were gastrointestinal symptoms, most of them minor, occurring in about 20%, and leading to discontinuation in about 3%, of patients. Peptic ulcer or G.I. bleeding occurred in clinical trials in 0.6% (95% confidence interval: 0.2% to 1%) of approximately 1800 patients during their first 3 months of diclofenac treatment and in 1.6% (95% confidence interval: 0.8% to 2.4%) of approximately 800 patients followed for 1 year.

Gastrointestinal symptoms were followed in frequency by central nervous system side effects such as headache (7%) and dizziness (3%).

Meaningful (exceeding 3 times the Upper Limit of Normal) elevations of ALT (SGPT) or AST (SGOT) occurred at an overall rate of approximately 2% during the first 2 months of Voltaren treatment. Unlike aspirin-related elevations, which occur more frequently in patients with rheumatoid arthritis, these elevations were more frequently observed in patients with osteoarthritis (2.6%) than in patients with rheumatoid arthritis (0.7%). Marked elevations (exceeding 8 times the ULN) were seen in 1% of patients treated for 2-6 months (see WARNINGS, Hepatic Effects).

The following adverse reactions were reported in patients treated with diclofenac:

Incidence Greater Than 1% - Causal Relationship Probable: (All derived from clinical trials.)

Body as a Whole: Abdominal pain or cramps,* headache,* fluid retention, abdominal distention.

Digestive: Diarrhea,* indigestion,* nausea,* constipation,* flatulence, liver test abnormalities,* PUB, i.e., peptic ulcer, with or without bleeding and/or perforation, or bleeding without ulcer (see above and also WARNINGS).

Nervous System: Dizziness.

Skin and Appendages: Rash, pruritus.

Special Senses: Tinnitus.

*Incidence 3% to 9% (incidence of unmarked reactions is 1%-3%).

Incidence Less Than 1% - Causal Relationship Probable: (The following reactions have been reported in patients taking diclofenac under circumstances that do not permit a clear attribution of the reaction to diclofenac. These reactions are being included as alerting information to physicians. Adverse reactions reported only in *worldwide marketing experience* or in the literature, not seen in clinical trials, are considered rare and are italicized.)

Body as a Whole: Malaise, swelling of lips and tongue, photosensitivity, *anaphylaxis*, anaphylactoid reactions.

Cardiovascular: Hypertension, congestive heart failure.

Digestive: Vomiting, jaundice, melena, aphthous stomatitis, dry mouth and mucous membranes, bloody diarrhea, hepatitis, *hepatic necrosis*, appetite change, pancreatitis with or without concomitant hepatitis, *colitis*.

Hemic and Lymphatic: Hemoglobin decrease, leukopenia, thrombocytopenia, *hemolytic anemia, aplastic anemia, agranulocytosis*, purpura, *allergic purpura*.

Metabolic and Nutritional Disorders: Azotemia.

Nervous System: Insomnia, drowsiness, depression, diplopia, anxiety, irritability, *aseptic meningitis*.

Respiratory: Epistaxis, asthma, laryngeal edema.

Skin and Appendages: Alopecia, urticaria, eczema, dermatitis, *bullous eruption, erythema multiforme* major, angioedema, *Stevens-Johnson syndrome*.

Special Senses: Blurred vision, taste disorder, reversible hearing loss, scotoma.

Urogenital: *Nephrotic syndrome*, proteinuria, *oliguria, interstitial nephritis, papillary necrosis, acute renal failure*.

Incidence Less Than 1% - Causal Relationship Unknown: (Adverse reactions reported only in worldwide marketing experience or in the literature, not seen in clinical trials, are considered rare and are italicized.)

Body as a Whole: Chest pain.

Cardiovascular: Palpitations, *flushing*, tachycardia, premature ventricular contractions, myocardial infarction.

Digestive: Esophageal lesions.

Hemic and Lymphatic: *Bruising*.

Metabolic and Nutritional Disorders: Hypoglycemia, *weight loss*.

Nervous System: Paresthesia, memory disturbance, nightmares, tremor, tic, *abnormal coordination*, convulsions, *disorientation, psychotic reaction*.

Respiratory: Dyspnea, hyperventilation, edema of pharynx.

Skin and Appendages: Excess perspiration, *exfoliative dermatitis*.

Special Senses: Vitreous floaters, night blindness, amblyopia.

Urogenital: Urinary frequency, nocturia, hematuria, impotence, vaginal bleeding.

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Skin cancer prevention: a peer education model

Douglas J. Reding, MD; Virginia Fischer, MS; Paul Gunderson, PhD; and Karen Lappe, RN, BSN, Marshfield

Results from a quasi-experimental project indicate that skin cancer prevention and sun protection education can successfully be promoted by using peer educators. Senior high students (40) facilitated and taught a sun protection curriculum to third-grade students (508) enrolled at the experimental sites. The curriculum's effects were assessed with pre-program, post-program, and 6-month follow-up survey instruments. The experimental sites using high school (peer) facilitators were effective in conveying knowledge to younger students based on knowledge gained on the post-program surveys. Overall, the intervention group demonstrated a mean improvement of 3.4 questions on the post-program survey, while the control group improved 0.1 questions ($p < 0.01$). Additional benefits included a knowledge gain by the peer facilitators, a self-reported possible increase in desired behavior change, and an improved attitude about sun protection. Implications for pediatric clinical practice are noted. *Wis Med J.1995;94(2):75-79.*

SINCE 1973, the incidence rate of melanoma has increased about 4% per year. There has been a steady increase in the number of non-melanoma skin cancers since 1988.[1] Cancer has been reported as the second leading cause of death among male farm residents and the leading cause of death among female farm residents.[2,3]

A series of protocols was developed as part of the Wisconsin Farmers' Cancer Control Program (WFCCP) to improve access to cancer education and screening for rural residents in Wisconsin. The program, funded by the National Institute for Occupational Safety and Health, was designed and implemented by staff at the National Farm Medicine Center in Marshfield in collaboration with the Wisconsin Department of Health and Human Services and the American Cancer Society--Wisconsin Division (ACS). Its goals were to identify barriers to health care for rural residents and to help improve the access of cancer screening and education, especially for skin cancer.[4]

In farm family focus groups conducted at the beginning of the project, three key recommendations were identified: the importance of education materials being simple and brief, the need for educating farm children on healthy lifestyles and cancer risks, and the need to conduct education on the farm. One way the educational component targeted the farming community was by working with an existing farm-oriented organization to deliver skin cancer prevention education to rural youth and adult farmers.

In an attempt to achieve a community diffusion effect necessary to reach those who may not be reached by other health professionals,[5,6] an intervention was designed using an existing school-based agricultural education program. The FFA organization was chosen as one vehicle to reach the farming community. The FFA organization is a national association of high school agriculture students preparing for careers in agricultural production, processing, supply and service, mechanics, horticulture, forestry, and natural resources. A prominent feature of the organization is the use of peer education whereby older students teach younger children principles about agriculture. Previous peer education programs in FFA have been focused

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1. When should you protect yourself from the sun?
   a. summer only
   b. spring and summer
   c. the whole year
2. The time of day when the sun is strongest is_____.
   a. every morning
   b. noon
   c. late afternoon
3. The best way to protect yourself from the sun is by using_____.
   a. baby oil
   b. sunblock
   c. tanning lotion
4. I will wear sunblock number _____ when I'm outside.
   a. 10
   b. 12
   c. 15 or greater
5. The skin type that needs the most sun-protection is _____.
   a. light color skin
   b. medium color skin
   c. dark color skin
6. In the ABC's of sun-protection, the A means _____.
   a. away
   b. after
   c. always
7. In the ABC's of sun-protection, the B means _____.
   a. block
   b. baby oil
   c. burn
8. In the ABC's of sun-protection, the C means _____.
   a. check
   b. color
   c. cover-up
9. What SPF number should be on sunblock that your family buys?
   a. 10
   b. 12
   c. 15 or greater
10. Which one does not protect you from the sun?
   a. long sleeve shirt
   b. baby oil
   c. sunblock

Fig 1.--Survey instrument for third-grade students.

on farm safety and their "Building Our American Communities" program.[7] Sun protection and skin cancer awareness fit easily into this format. Literature reveals that adults have difficulty making lifestyle changes because of habits and behavior learned in early childhood.[8] It is believed that the full potential of health education can be reached through the education of our youth. An additional important reason for directing cancer education programs at youth is that children may take home specific messages which may lead to parental and older sibling action.[9]

The goal of the demonstration project was to deliver sun-protection education to youth through the FFA organization. For this project, which took place in the 1991-1992 school year, three northern Wisconsin counties were chosen--Barron, Rusk, and Shawano--because of their high farming populations and their distance from any large tertiary care center. School personnel (ie, agriculture teachers who serve as FFA advisors and curriculum coordinators) from six high schools in the pilot counties were contacted. Meetings were also held with school boards and curriculum committees to elicit their approval and support. The planning process involved the ACS staff, state FFA representatives, local FFA advisors, and FFA members to design the plan of implementation.

It was felt that this would ensure successful integration of existing educational materials into the project, with the hope that these two organizations could continue their alliance once funding for WFCCP was terminated.

Method

The Children's Guide to Sun Protection K-3, developed by the ACS and the American Academy of Dermatology was used for the intervention.[10] Background information on the basic anatomy of the skin, skin cancer, the sun, the damage it causes, and methods of sun protection were included in the curriculum. Learning objectives, lesson plans, work sheets, and hand-outs dealing with sun protection were provided.

A survey instrument consisting of 10 knowledge-based questions about sun protection was developed for the third-grade students (Fig 1). The survey instrument was tested, and checked for validity and reliability. A pre-program survey preceded the first FFA facilitator presentation to the third-grade students at intervention sites, and a post-program survey was administered at the conclusion of the second presentation. Six months later, a follow-up survey was administered to these same students by their fourth-grade teachers. Control groups were surveyed with the identical instrument in the same manner as the intervention groups, with no education session between the pre-program and

the post- program surveys.

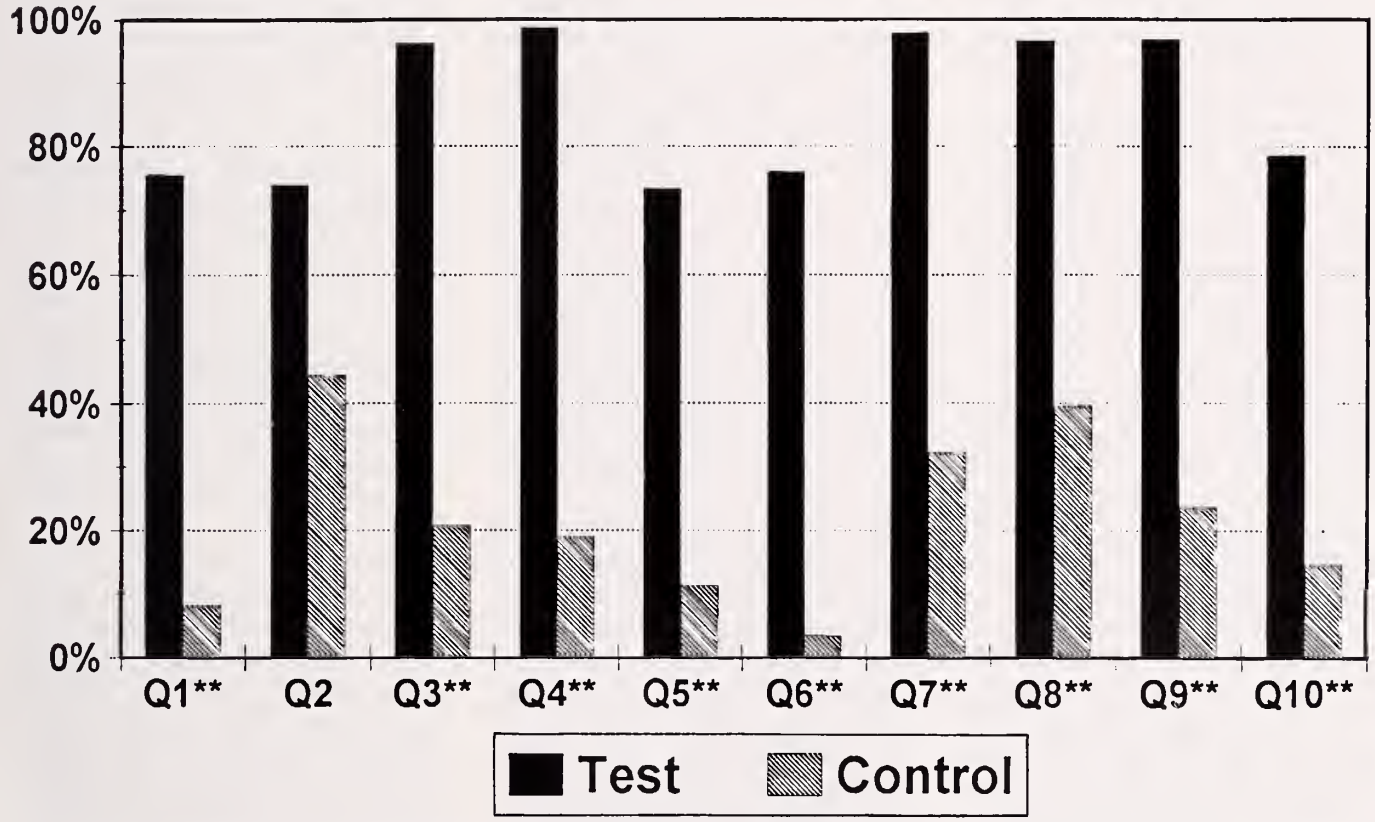
Students who correctly responded to a question on the post-program survey after incorrectly answering it on the pre-program survey were said to have had a knowledge gain for that question. For each of the 10 questions, the number of students experiencing knowledge gain in the intervention and control groups were compared using chi-square tests. The control and intervention group change score values were compared using the Mann-Whitney U test. A somewhat conservative significance level of 0.01 was used in comparisons of the 10 questions.

WFCCP staff and ACS staff trained 40 FFA members (peer facilitators) at a 1-day workshop. The workshop included background information on skin cancer and sun protection, the introduction and practice of the sun-protection curriculum, and some teaching skills training. They also received instructions on administering the pre-program and post-program surveys to the third-grade students.

The facilitators presented the education materials (emphasizing the ABCs of sun protection)[10] to third-grade students in their school districts in April and May (in preparation for peak sun exposure time in the summer). The education was conducted in two 30- to 40-minutesessions on 2 days within a 1-week period. The timing of the education sessions was coordinated by the advisors associated with each school facilitator group.

As part of the education process, the third-grade students used sun-protection activity sheets (work sheets and coloring sheets with a sun protection theme) which could be taken home. Other materials distributed at the end of the intervention to be taken home included the skin cancer brochure developed by WFCCP specifically for farmers, an informational skin cancer sheet from ACS, a bookmark with the ABCs of sun protection, and a sun protection factor (SPF) #15 sunscreen sample.

Within each school district, control classrooms were chosen at random by the advisors. Wherever possible, an outlying school within the district became the control. Seven of the 26 classrooms acted as controls, with the remaining nineteen classrooms designated for intervention.



*Students selected for incorrectly answered question on pre-survey and correctly answered question on post-survey
**Test and Control significantly different ($p < 0.01$)

*Fig 2.--Students who improved from pre-program to post-program survey.**

Table 1.--Results of three administrations of the knowledge survey: mean score for each survey by test group.

	Mean	SD	95% CI	Mean	SD	95% CI	Mean	SD	95% CI
Intervention	5.8	±1.9	(5.6, 6.0)	9.2	±1.1	(9.1, 9.3)	8.1	±1.3	(7.9, 8.3)
Control	5.9	±2.0	(5.5, 6.3)	6.0	±1.8	(5.7, 6.3)	7.8	±1.5	(7.5, 8.1)

Forty FFA, FHA , and Natural Helper members (46% boys and 54% girls) were involved in teaching the sun protection curriculum. Thirty-three (83%) completed all three surveys and were included in the data analysis.

Results

The survey was administered to 508 third-grade students. The three survey instruments were fully completed by 401 (79%) students and these were included in the evaluation process. Lack of paired responses in 107 students (80 intervention, 27 control) was due to absences when any one of the surveys was administered or to the relocation of students from one school year to the next.

There were no significant differences between the intervention and control third-grade students on any of the pre-program survey questions. Scores indicate that the two groups had similar background knowledge levels regarding sun protection at the start of the project.

For nine of the 10 questions, the intervention group had a statistically significant ($p < 0.01$) higher proportion of students experiencing knowledge gain than did the control group for pre-program to post-program surveys (Fig 2).

Overall, the intervention group had significantly improved scores on the post survey, in comparison with the control group scores which showed little change ($p < 0.01$). The mean improvement for the intervention group was 3.4 questions , while the control group showed virtually no improvement (mean = 0.1 questions) (Table 1).

The sun protection education was given to the control groups in a brief session after the post-program survey was administered. Therefore, it was difficult to interpret the results of comparisons between the intervention and control groups for 6-month follow-up data. Both groups showed a significant improvement in knowledge from pre-program to 6-month follow-up surveying (Table 2).

Time and effort logs were completed by peer facilitators and advisors. The time spent in preparation and presentation of the sun protection education sessions by the peer facilitators ranged from 6 to 27.5 hours with the average being approximately 16 hours (including 8 hours of training and travel time).

Advisors reported an average time of 26 hours (ranging from 12 to 62 hours) spent implementing the program. Since several districts expanded the program to include other classrooms and meetings, the time represented may not truly reflect the needs for the FFA program as originally designed (third-grade students only). The FFA pilot project materials costs were $0.55 per third-grade student and $3.50 per facilitator.

An additional goal of this project was to influence the behavior and attitudes of the facilitators regarding sun protection, with special emphasis on "the more sun one gets exposed to, the greater the chances of developing skin cancer." To this end, the facilitators were assessed by the use of a 13-question survey instrument about skin cancer and sun protection, which included attitude, behavior, and knowledge questions. The identical instrument was used three times: at the beginning of the 1-day training session, at the end of the 1-day training session, and 6 months later.

For the 33 facilitators completing all surveys, 6 (18%) improved their overall score on the three knowledge questions. On each of the two behavior questions on the survey, an increase in the percentage of facilitators who were likely to practice the desired behavior was seen.

Discussion

A definite interest of the third-grade students in sun protection and a positive acceptance of the peer facilitators were noted in observations by WFCCP staff in 10 of the 19 classroom interventions. Evaluations by the facilitators indicated that third-grade students identified them as teachers of sun protection information and appeared to recall the sun protection education project within the next 3 months.

Knowledge retention could be demonstrated through 6-month follow-up surveys. There was a slight loss of knowledge by the intervention group on the 6-month follow-up survey, but they still achieved an overall knowledge gain of two questions for the sun protection intervention.

There is a possibility that the sun protection education could become part of a pediatric practice since this is an important prevention issue that older children could take control of themselves. The pediatrician or family physician could distribute the ABCs sun protection bookmark and briefly discuss it with patients 8 or more years, with a special emphasis on the need for reducing total sun exposure over a lifetime. Sun protection education to parents during

Table 2.--Results of three administrations of the knowledge survey: percent correct on each question by test group.

	Intervention (n-294)			Control (n=107)		
Question	*Pre-program*	*Post-program*	*6-month follow-up*	*Pre-program*	*Post-program*	*6-month follow-up*
1	59.9	86.4	76.9	54.2	53.3	71.0
2	83.0	90.8	85.0	83.2	89.7	80.4
3	72.1	98.0	98.0	72.9	75.7	98.1
4	50.3	99.0	96.6	45.8	50.5	83.2
5	64.3	85.7	78.2	58.9	54.2	77.6
6	11.2	77.2	21.1	17.8	15.0	27.1
7	69.4	98.3	92.5	73.8	75.7	86.9
8	60.2	98.0	84.7	69.2	68.2	86.9
9	47.3	97.6	93.9	48.6	53.3	88.8
10	60.2	90.1	78.6	68.2	62.6	79.4

well-child visits by pediatricians or family physicians could also be effective. Providing this information during the newborn period or in infancy could also help prevent childhood sunburns which are associated with skin cancer.[11,12]

Conclusion

The findings of this educational intervention demonstrate the effectiveness of peer facilitators (high school students) in educating younger students concerning a highly sensitive issue regarding human health, specifically skin cancer. Pre-program and post-program survey analyses showed significant increases in third-grade student sun protection knowledge gained in the intervention group.

The success of this project would suggest that this education intervention should be replicated on a larger scale to determine if a larger intervention could sustain similar educational gains. If successful on a larger sample size, this teaching module could be implemented in any FFA or similar organization on a national scale. Coalitions could be developed with the ACS and the FFA organization to sustain this activity. Other human health issues concerning heart disease, cancer, and safety could most likely be adapted into this format.

Acknowledgement

WFCCP was a cooperative agreement with the National Institute for Occupational Safety and Health, with Geoffrey Calvert, MD, MPH, as project officer.

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Memo

To: **President Clinton**
Members of the House and Senate

From: **The 300,000 member physicians of the American Medical Association**

Re: **Getting the job done on health care**

We believe there are several workable measures that can be passed now to help achieve our ultimate goal – making quality health care affordable and accessible to all Americans.

As the country awaits the State of the Union address, the member physicians of the American Medical Association set forth these practical recommendations to improve health care for our patients.

Insurance Reform – Pass insurance reforms that will make sure Americans will not lose their coverage if they change jobs or get sick.

Medicare Reform – Reform our Medicare system so it will be there for the next generation of elderly and disabled.

Medical Savings Accounts – Make MSAs available so people can pay for routine medical care with pre-tax dollars.

Patient Protections – Enhance patient choice, disclosure and assure greater physician involvement in corporate decisions about patient care.

Liability Reform – Enact meaningful liability reform to ensure fair compensation to patients with legitimate claims while eliminating excessive malpractice awards that lead to defensive medicine.

Regulatory Relief – Free both physicians and patients from the ever-increasing burden of needless and wasteful paperwork, regulations, obsolete anti-trust rules and red tape.

Medical Education and Research – Protect medical education and research so that we can find cures for killers like AIDS and cancer.

Public Health Problems – Fight social problems like violence and smoking — problems that cost billions of dollars and millions of lives.

These measures are sensible things we can do now that will make a difference for all of us. So, as we begin our nation's 104th Congress, we renew our pledge to the health of America. As the voice of the medical profession, we pledge to do everything we can to help make these things happen. It is our contract with America, and we fervently hope that every American will join us.

American Medical Association
Physicians dedicated to the health of America

Retroperitoneal paragangliomas: Natural history and review of the literature

Kenneth T. Bastin, MD; Richard A. Steeves, MD; and Kennedy Gilchrist, MD, Madison

Retroperitoneal paragangliomas are uncommon neoplasms that arise from neural crest cells. Typical retroperitoneal sites of origin include adrenal medulla, organs of Zuckerkandl, and along sympathetic and parasympathetic nerves. We present a case of a woman diagnosed with retroperitoneal paraganglioma treated with debulking, intraoperative radiotherapy and external beam radiation therapy. She experienced a 7-year disease-free interval prior to symptomatic metastatic recurrence. Such remissions are consistent with the natural history for paragangliomas. The purpose of this report and literature review is to summarize the pertinent biologic and therapeutic options for these uncommon tumors. *Wis Med J.1995;94(2):81-83.*

PARAGANGLIOMAS CAN ARISE from virtually any site in the body containing embryonic neural crest tissue. These tumors are typically classified by site of origin, with examples including carotid body tumors, glomus jugulare and vagal tumors when arising from the head and neck. Carotid body tumors are also called "chemodectomas." Paragangliomas can be histologically designated as benign or malignant. We present a case of a woman with a retroperitoneal paraganglioma which, despite aggressive treatment recurred and metastasized. Her clinical course is not atypical for retroperitoneal paragangliomas.

Case report

In 1983, a 25-year-old woman went to her gynecologist for a routine pelvic examination and Papanicolaou smear. She was gravida 2, para 1, abortus 1, and seen 18 months since an uncomplicated delivery. During bimanual examination a right posterior pelvic retroperitoneal mass was appreciated. Subsequent pelvic ultrasound confirmed a 5-cm mass in the right pelvis. Pelvic exploration in July 1983 through a Pfannenstiel incision revealed a mass extending from the sacral promontory to the coccyx. The tumor was totally excised in piecemeal with difficult hemostasis. Pathology revealed paraganglioma (Figure I). Postoperatively, the patient received 4680 centigrays (cGy) opposed anterior and posterior external beam radiation in 26 fractions to the tumor bed using 10 mV photons.

The patient enjoyed a 7-year disease-free interval until November 1990 when she was diagnosed with a symptomatic recurrence at the junction of the fifth lumbar vertebra and first sacral vertebra (L5/S1) , and concurrent metastatic disease in the right acetabulum and anterior abdominal wall (Figure 2). She underwent resection of the rectus abdominis and L5/S1 masses. Intraoperative electron radiation therapy totalling

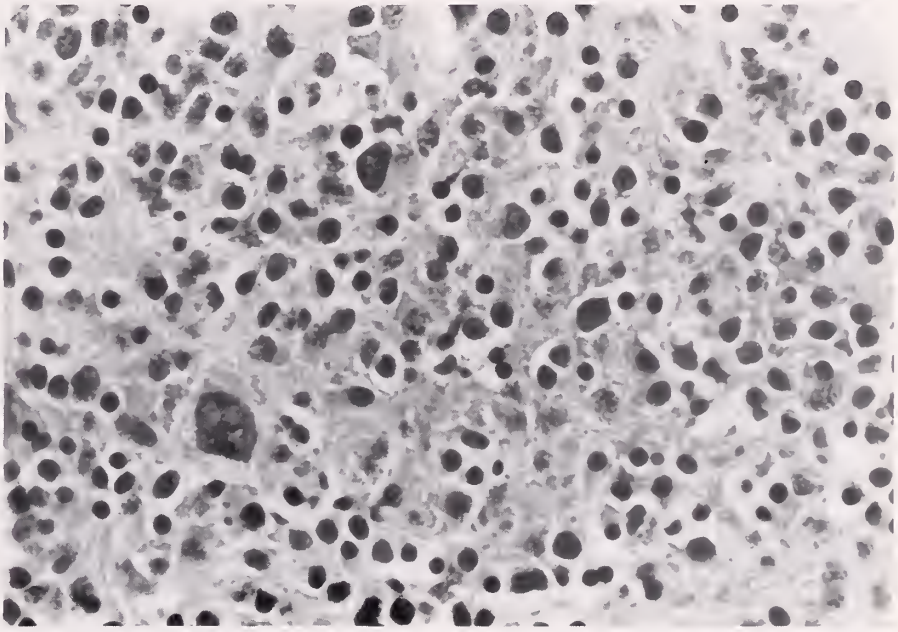

Fig 1.--Histopathology at the original resection reveals a representative nest of paraganglioma with polygonal cells containing finely granular cytoplasm.Mitotic figures were infrequent with occasional larger nuclei present.(X 200)

Department of Human Oncology, divisions of radiation oncology and pathology, at the University of Wisconsin Hospitals and Clinics. Reprint request to: Richard A. Steeves, MD, PhD, K4/B100, 600 Highland Ave, Madison, WI 53792-0001. Copyright 1995 by the State Medical Society of Wisconsin.

1800 cGy was delivered to the retroperitoneal mass in a single fraction. Postoperatively, the L5/S1 site received an additional 4000 cGy of external beam radiation in 20 fractions. Palliative radiotherapy was also delivered to the left acetabulum.

The patient did well for the next 18 months, but in January 1992 she developed bilateral tingling in her feet. Her work-up included magnetic resonance imaging of the spine and the pelvis, which revealed metastases to the first and third lumbar vertebrae.

She received radiation therapy to the spine, with resolution of lower extremity tingling. In August 1992, she developed metastases in the occipital bone and left ischium, and these were treated with palliative radiotherapy totalling 4500 cGy in 18 fractions. In February 1993, she required additional radiotherapy following the diagnosis of new metastases to the thoracic and cervical spine and base of skull. Despite multiple courses of radiotherapy and previous surgery, the patient maintained a full-time job with a Karfnosky performance of 90%. As of the summer 1994 she had pain-free survival, albeit it with known disease.

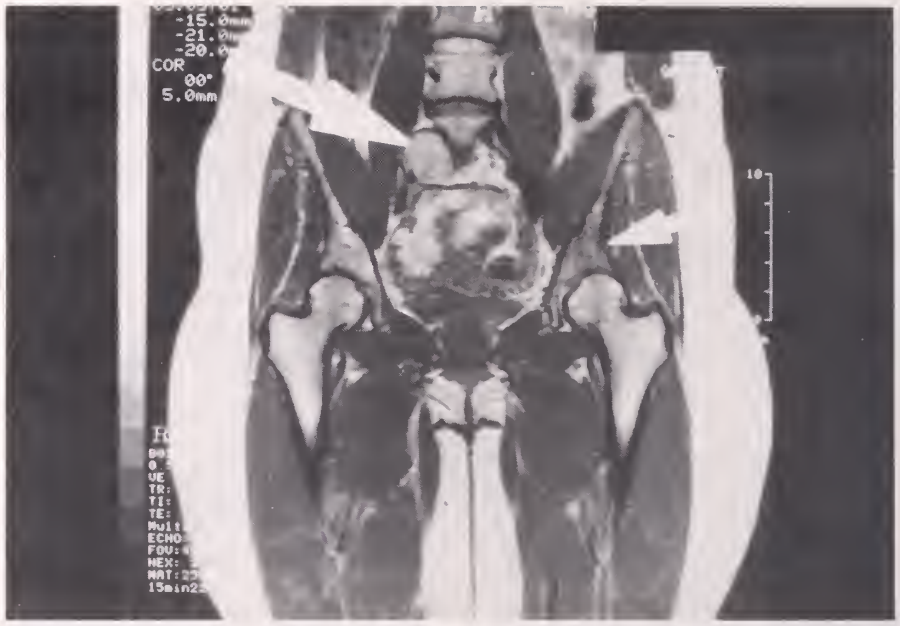

Fig 2.--Magnetic resonance imaging with a gadolinium enhancement showing recurrence at the original L5/S1 site (large arrow) as well as a new metastasis at the left acetabulum (small arrow).

Discussion

Paragangliomas arise in any body site containing neuroendocrine cells. Most clinical series have described treatment outcome and therapy for chemodectomas. Paragangliomas of the retroperitoneum have been best analyzed in a retrospective report from Memorial et al.[1] In their report, the cases of 22 patients with confirmed retroperitoneal paraganglioma from 1949 to 1990 were retrospectively reviewed and showed an equal sex distribution with a mean age at diagnosis of 42 years. Of these tumors, 36% actively secreted catecholamines, resulting in sympathetic stimulation, hypertension, headache, and palpitations. Half of these paragangliomas developed metastases and were deemed "malignant." Interestingly, however, even for tumors "completely" resected, the 5- and 10-year disease-free survival rates were 75% and 45% respectively. Two of the 11 patients who developed metastases did so more than 7 years after their initial diagnosis. Overall, distant sites of metastasis included bone, liver, peritoneum, pelvis, ovaries, cervical lymph nodes, and lung.

Thus, the natural history for retroperitoneal paragangliomas is consistent with long periods of disease-free survival, as seen in our case report. This natural history is similar to other paragangliomas, including those arising in the mediastinum.[2] Treatment of paragangliomas has historically included surgery, radiation, and chemotherapy. Surgery will remain the mainstay for definitive tissue diagnosis and debulking. Radiation therapy has established a curative role in treating head and neck chemodectomas which cannot be easily resected without significant surgical morbidity.

In our case report, a patient with biopsy-proven paraganglioma following resection received maximum adjuvant radiotherapy to the tumor bed which resulted in a 7-year disease-free interval. On recurrence in the L5/S1 region, she received intraoperative radiotherapy that produced a 3-year disease-free interval. A form of radiotherapy not available at our institute is that of adjuvant radionuclide iodine-131 (I^{-131}) linked to metaiodobenzylguanidine (MIBG), a substance actively taken up by the paraganglial tissues. Several authors[3,4] have reported benefit using this therapy. Chemotherapy has been reported to offer good response for malignant paraganglioma.[5]

Summary

Retroperitoneal paragangliomas are rare neoplasms usually treated with aggressive surgical resection and adjuvant radiotherapy, and less frequently with chemotherapy and experimental MIBG. The natural history of paragangliomas is marked

by long disease-free intervals and long intervals preceding the development of metastasis. These patients need to be correctly diagnosed, treated aggressively when appropriate, and followed for a long time before deemed as being cured.

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Abstract
Subclinical hormone secretion by incidentally discovered adrenal masses

Arch Surg.1994;129:291-296

Robert H. Caplan, MD; Pamela J. Strutt, RN; and Gary G. Wickus, PhD, La Crosse

Objective
To determine the frequency of subclinical hormone secretion in incidentally discovered adrenal masses.

Design
We reviewed the radiologic reports of 1,779 consecutive computed tomographic scans of the chest, abdomen, and pelvis.

Setting
Regional referral medical center.

Patients
Eighty-nine patients with abnormalities of one or both adrenal glands were identified. Patients with nonadrenal gland malignant neoplasms, primary aldosteronims, adrenal hemorrhage, and death or severe illness were not investigated. The final study group consisted of 26 patients with incidentally discovered adrenal masses.

Main outcome measures
Aldosterone secretion was assessed by measuring plasma renin activity and the plasma aldosterone concentration in patients with unexplained hypokalemia. We evaluated cortisol secretion by performing a 1 mg overnight dexamethasone suppression test and by measuring the corticotropin concentration at 8 AM by a sensitive method. In patients with low corticotropin values, we also measured the 24-hour urinary excretion of free cortisol and 17 ketosteroids and assessed diurnal variation by measuring plasma cortisol concentrations at 8 AM and 4 PM. Adrenal medullary function was studied by measuring urinary free catecholamines.

Results
One patient had unrecognized primary aldosteronism, two patients had elevated free catecholamine excretion, and three patients (12%) had subclinical Cushing's syndrome.

Conclusion
Based on our observations and a review of the literature, we concluded that subclinical hormone secretion, especially cortisol secretion, is more common in patients with incidentally discovered adrenal masses than previously appreciated. Surgeons and anesthesiologists must be alert to the possibility that adrenal insufficiency or a hypertensive crisis may develop in the perioperative period in patients with incidentally discovered adrenal masses.❖

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Medical society achieves major tort reform victory

After consideration of 20 amendments and several hours of debate, the Wisconsin State Assembly on Feb 2 passed Assembly Bill 36, which caps non-economic damages in medical malpractice cases at $350,000. The bill also reinstates and extends the $150,000 cap on wrongful death suits to medical liability cases and provides for payment of future medical expenses on an as-incurred basis. Passage of the bill came within the first 30 days of the 1995-1996 legislative session as promised by Assembly Speaker David Prosser (R-Appleton) who had vowed to bring this issue and other initiatives held up in the past by the Democratic leadership to the floor. Prosser said that he had promised to bring the bill up quickly because he believed it to be good public policy. The bill passed with bi-partisan support on a vote of 64-33, with two members absent.

Rep Mark Green (R-Green Bay) authored the bill and along with Rep Sheryl Albers (R-Loganville), chair of the Assembly Committee on Insurance, Securities and Corporate Policy, guided it through the process. Green told the Assembly that the cap will lower Patient Compensation Fund premiums by 16.7% and help relieve the liability burden suffered by physicians across the state. (If enacted, a portion would be used to offset the PCF deficit.) Green pointed to the 16 obstetric shortage areas in the state as a consequence of high malpractice premiums, which can reach $64,000 for OB/GYNs.

Newly elected Rep Sheldon Wasserman, MD, (D-Milwaukee) an OB/GYN, spoke in favor of the bill, relating a compelling personal experience where he was threatened with a lawsuit by the trial attorney-father of the infant he was delivering. He spoke about OB/GYN colleagues who leave their practices early because of high malpractice premiums and the specter of being sued. Rep Frank Urban, MD, (R-Brookfield) also testified for the cap.

State Rep Judy Robson (D-Beloit) led the fight against AB 36 in the Assembly Insurance Committee and along with Minority Leader Walter Kunicki, (D-Milwaukee) worked to defeat the bill on the Assembly floor. Robson authored several amendments to weaken or kill the bill. In committee, she offered an amendment to end the cap in the year 2000. That effort failed. She also attempted on two occasions to raise the cap to $1 million, a move that would have killed the bill. Her effort in committee was defeated on a party line vote. She offered the same amendment on the Assembly floor, and on a crucial vote, that amendment was defeated, 58-40. Robson then offered an amendment on the floor that would triple the cap if the health care provider was under the influence of controlled substances or an intoxicant. Rep Green refuted her argument, explaining that in those instances, plaintiffs would have a good case for punitive damages, which would continue to be unlimited.The Assembly did adopt an amendment offered on behalf of the trial attorneys by state Rep William Lorge (R-Bear Creek). Attorneys are concerned that the amount of their award would be jeopardized by the portion of the bill that provides for payment of future medical expenses on an as-incurred basis. Under the amendment, attorneys will collect their fees before their clients receive the full amount of their award.

AB 36 has been sent to the Senate where Sen Joanne Huelsman (R-Waukesha) is expected to take the lead. After it receives a public hearing by a Senate committee, the bill will be debated by the full Senate.

The following representatives voted in favor of final passage: Prosser (R), Ainsworth (R), Albers (R), Black (D), Brancel (R), Brandemuehl (R), Coleman (R), Dobyns (R), Dueholm (D), Duff (R), Foti (R), Freese (R), Gard (R), Goetsch (R), Green (R), Gronemus (D), Grothman (R), Gunderson (R), Hahn (R), Handrick (R), Hanson (D), Harsdorf (R), Hasenohrl (D), Hoven (R),Hubler (D), Huebsch (R), Hutchison (R), Jensen (R), Johnsrud (R), Kaufert (R), Kelso (R), Klusman (R), Kreibich (R), Ladwig (R), Lasee (R), Lazich (R), Lehman (R), Linton (D), Lorge (R), Meyer (D), Murat (D), Musser (R), Nass (R), Olsen (R), Ott (R), Otte (R), Ourada (R), Owens (R), Porter (R), Powers (R), Ryba (D), Schneider (D), Schneiders (R), Seratti (R), Silbaugh (R), Skindrud (R), Underheim (R), Urban (R), Vrakas (R), Walker (R), Ward (R), Wasserman (D), Wilder (D), Zukowski (R).❖

Public health

Assessing the increase in firearm-related homicides in Wisconsin, 1979-1993

Patrick L. Remington, MD, MPH; Leah Stahlsmith; Ray Nashold, PhD, Madison

RECENTLY, public concern has focused on the increase in violence in American society, particularly the increase in homicides caused by firearms.[1-3] As reported in the October issue of the *Wisconsin Medical Journal*,[4] the number of homicides caused by firearms in Wisconsin increased from an average of 85 in 1981-1983 to an average of 143 in 1991-1993. The purpose of this report is to assess this trend in firearm-related homicides among specific demographic subgroups in Wisconsin.

Methods

Firearm-related homicide data were obtained from the Wisconsin Center for Health Statistics from 1979 to 1993 for whites and blacks. Population estimates were obtained from the 1980 and 1990 US census. Estimates for non-census years were interpolated or extrapolated.

To provide more reliable estimates, we calculated the firearm homicide rates for the 5-year periods in 1979-1983 and 1989-1993 for whites and blacks only. To estimate the number of "expected" firearm-related homicides annually in 1989-1993 for each age-sex-race group, and to account for changes in the population, the 1979-1983 rate was multiplied by the 1991 population estimate. This "expected" number of firearm-related homicides was compared to the "observed" number for 1989-1993.

Results

Using the rates in 1979-1983, we calculated the expected number of firearm homicides for each demographic group annually during 1989-1993 (table). The differences between the observed and expected number of firearm-related homicides for each age group for blacks and whites are shown in the figure. Overall, there were 47 more firearm-related homicides annually in 1989-1993 compared with 1979-1983 (table). During this period, the overall firearm-related homicide rate increased 1.5-times, from 1.9/100,000 in 1981 to 2.8/100,000 in 1989-1993.

There was little increase in the number of firearm-related homicides among white males, with only two more firearm homicides than expected each year from 1989-1993. There was, however, a moderate increase among young white males (15-24 years), with six more firearm homicides than expected each year from 1989-1993 (figure).

Among white females, overall there were five fewer firearm-related homicides observed each year in 1989-1993 compared with 1979-1983. In contrast to white males, there was no increase in the number of firearm-related homicides observed in any age group among white females.

The greatest increase in firearm-related homicides in 1989-1993 was among black males, with 47 more firearm-related homicides each year than expected. More firearm homi-

Changes in firearm-related homicides in Wisconsin, 1979-1993.

Demographic group	Rate* (1979-1983)	Rate* (1989-1993)	Expected No. (1989-1993**)	Observed No. (1989-1993)	Excess No. (observed-expected)	Relative change (%) in rates***
Male						
white	1.5	1.7	34	36	+2	+13%
black	21.6	60.2	26	73	+47	+179%
Female						
white	0.8	0.7	18	13	-5	-14%
black	6.1	8.5	8	11	+3	+39%
Total	1.9	2.8	86	133	+47	+47%

*Crude rate/100,000 population.
**Determined by applying the rate in 1979-1983 to the 1991 population estimate. See methods for description of analyses.
*** 1989-1993 v 1979-1983.

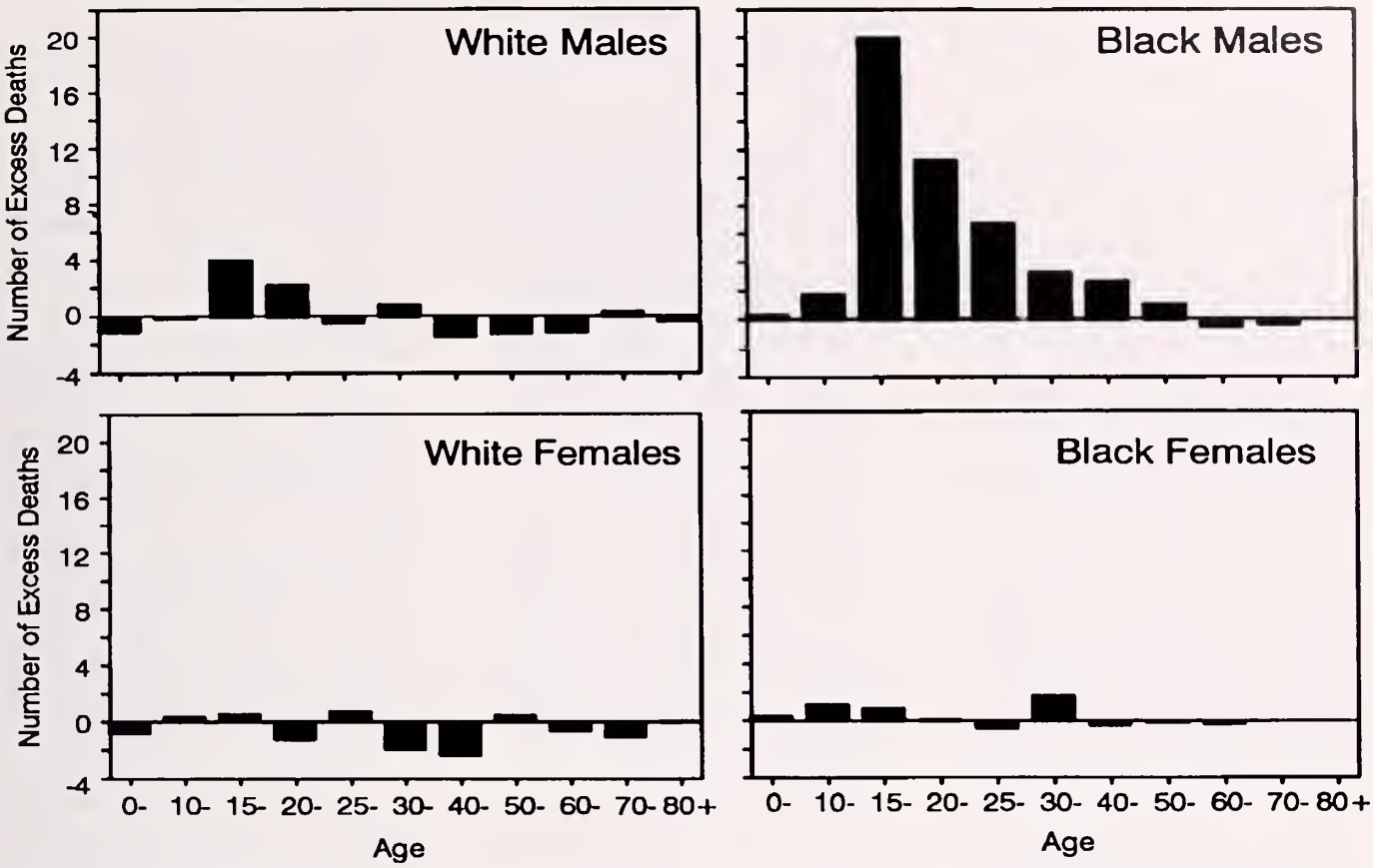

Fig.--Difference in the annual number of firearm-related homicides in Wisconsin in 1989-1993, compared with 1979-1983. See methods for description of analyses.

cides than expected occurred in every age group, with the exception of those 60 and older. As with white males, the greatest increase in firearm-related homicides occurred among black males ages 15-24, with 31 more firearm-related homicides that expected each year (figure). Finally, among all black females, there were three more firearm-related homicides each year from 1989-1993 than expected.

Comment

Like the rest of the nation, Wisconsin has experienced an epidemic of firearm-related homicide among young black males. This is in contrast to the trends for the remainder of the population, in which there has been little change in the number of firearm-related homicides.

Traditional assessments of firearm-related homicides have compared rates *between* demographic subgroups in the population. For example, the firearm-related homicide rate in 1979-1983 among black males was 14 times the rate among white males. In this report, we compared trends in firearm-related homicide rates *within* demographic subgroups, by using the rate in 1979-1983 to predict the expected rate in 1989-1993. Using this method, the single greatest increase in the number of firearm-related homicides in Wisconsin was found among black male teenagers.

Having used the public health approach to identify young black men as a high risk group for firearm-related homicide, this same model can be used in developing prevention strategies.[3] Similar to motor vehicle crash injury prevention efforts, public health agencies should strive to understand the risk factors involved. Efforts are being made to identify aspects of the "agent" or the firearm itself, as well

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The public health column is not reviewed by the *WMJ* Editorial Board. From the Wisconsin Division of Health. Dr Remington is the chief medical officer for Chronic Disease Control, Bureau of Public Health, Wisconsin Division of Health. Stahlsmith is a graduate student in the Epidemiology Program at the University of Wisconsin-Madison. Dr Nashold is the director of the Center for Health Statistics. Reprint requests to: Patrick Remington, MD, MPH, Wisconsin Division of Health, 1414 E Washington Ave, Room 251, Madison, WI, 53703-3041. Copyright 1995 by the State Medical Society of Wisconsin.

as the individual and environmental characteristics that make young black men at increased risk of firearm homicide.[3]

Currently, a number of community-based programs, such as the Milwaukee Violence Prevention Coalition, are addressing this important public health problem. The Black Health Coalition of Wisconsin is conducting a study to examine family characteristics related to "resiliency" from violence. Also, Milwaukee County's Fighting Back Initiative is working with the Carter Center on a project entitled "Not Even One," to identify factors associated with firearm-related deaths. The Department of Emergency Medicine at the Medical College of Wisconsin has established an Integrated Firearm Injury Reporting System collaborating with the Medical Examiner of Milwaukee County, law enforcement agencies, and the Wisconsin Crime Lab - Firearms Division. Coupled with the Wisconsin Division of Health's recently established Firearm Injury Surveillance System, accurate information on all firearm-related injuries and deaths in the state will soon be available.[6] The information collected by this system, and by others, is essential for the development of effective community-based programs in Wisconsin.[7]

Acknowledgments

We appreciate the comments and suggestions of Mathew Reeves, Thomas Van Gilder, MD, Murray Katcher, MD, Trudy Karlson, Alfred Blumstein, Barbara Chatterjee, Stephen Hargarten, MD, Sheryl Weir, Olusegun Sijuwade, and Susan Wood.

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Making the most of your 401(k) plan

Michael J. Dolan, CLU, ChFC, Madison

MORE AND MORE companies are offering 401(k) plans to employees. Yet many employees fail to take full advantage of this superb way to save for retirement.

If you have the option of participating in a 401(k) plan, here's what you need to know:

These "defined contribution" plans are the opposite of traditional "defined benefit" pension plans. If your company offers a traditional pension, you know how much you will receive as a retirement benefit. The amount may actually be spelled out in dollars and cents or, more likely, be based on a formula taking into account age, earnings and length of service. Either way, you can be pretty sure that you will receive the promised pension.

Profit-sharing and 401(k) plans, however, are called defined contribution plans because it's the amount that can be contributed and not the benefit itself that is spelled out in advance. How much you will actually receive in retirement benefits from a 401(k) plan depends on how much you contribute to that plan and on the performance of the investments you choose. Many employees fail to contribute as much as they can, and many are far too conservative in their investment choices.

Each year, the federal government limits the amount that can be contributed to a 401(k) plan on a tax-deferred basis. For 1994, this maximum is $9,240; however, your employer may cap contributions at 10% or 15% of salary.

Many employers match employee contributions. If your company puts in 50+ cents on the dollar, that's an immediate 50% return on your investment, a return you lose if you fail to contribute.

Diversity the investments within your 401(k) plan. Don't stick to your company's stock. Doing so puts your future retirement income as well as your current income in one single basket; if your company runs into trouble, so do you. And, if you have 10 or more years before you retire, don't invest solely in "conservative" fixed-income investments; that's a sure way to lose buying power to inflation over time. Instead, consider putting at least a portion of your retirement money in common stock with the potential for growth.

Monitor your investment by reading the annual statement you get from your company. It will show the beginning value of your account, your contributions and any employer contributions during the year, plus the ending value of the account and the net return from investment.

Pay attention to the health of your company. While traditional pension plans are insured by the Pension Benefit Guaranty Corporation, there is no insurance on 401(k) plans. If your company is running into problems so that a bankruptcy or takeover appears likely, and if you have the option of taking a lump-sum withdrawal, you may want to consider taking the money and rolling it over into an individual retirement account (IRA). That way, you'll keep your money working for you until retirement.❖

Dolan is with the National Association of Life Underwriters. He is also vice president and chief operating officer of SMS Insurance Services.

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What works in Wisconsin: Talking to your patients about gun violence and gun safety

Shari Hamilton, assistant editor

IN RECENT MONTHS, Wisconsin physicians have heard a lot about gun safety, trigger locks and patient education but for some doctors it just hasn't seemed natural to incorporate questions about gun use into a regular health exam. Calls to the SMS by some of those physicians have prompted this article, asking us to relate what works in Wisconsin.

Children are alive with curiosity. But unlike the fabled cat tale, kids don't have nine lives to live. The SMS CHILD SAFE program is about protecting Wisconsin kids, before their curiosity leads them to investigate firearms and costs them their lives.

While adults sometimes deal with guns nonchalantly, paying little or no attention to the weapons because their presence is so common place, the weapons seemingly never cease to be a source of fascination for youth. Sometimes children are more aware of the location of guns and ammunition in the home than their parents are.

That message was pitched home to SMS President Richard G. Roberts, M.D., J.D., who practices family medicine in Belleville, last August when he had two young brothers in for elementary school physical exams.

Relates Dr Roberts: "When I asked my usual safety questions (Do you use seatbelts? Wear a bike helmet?), I also asked their mother: Do you have any guns in the home?"

The woman replied that she thought her husband used to have a gun, but that he got rid of it.

"The 7-year-old corrected his mother, as 7-year-olds love to do. `No, Mom. Dad's gun is in the shoe box on the top shelf of his closet.'

"The 5-year-old brother piped up: `And the bullets are in the middle drawer of his dresser.'

"Mom got all pale and sweaty," Dr Roberts reported as she contemplated the grave ramifications of her sons' words.

No wonder. The image sounds frightening like one that occurred Feb 13, 1995, in Stevens Point. Nine-year-old Jack Lipowski died as the result of a gunshot wound accidentally inflicted by his 11-year-old brother. The boys found a key and unlocked a drawer where their father kept a loaded gun. The 11-year-old, the news report said, removed the bullet clip from the gun, thought it was unloaded, pointed it at his brother while they were playing and pulled the trigger, fatally wounding his younger brother in the head.

Seventy-six Wisconsin youth (under age 19) died in 1993 (the latest year for which statistics are available). Two of the 76 deaths were unintentional; 38 were suicide (35 boys--32 white and 3 black-- and 3 white girls) and 36 were homicide (30 males--3 white, 26 black and 1 native American--and six females--2 white, 3 black and 1 native American).

In talking with patients, James Concannon, MD, a Kenosha emergency physician, says his best results come from examining with patients the risk of injury to self or children-- in much the same way you would discuss with a mother of young children the temperature setting on her hot water heater.

"Guns are all over. The problem is here. Children are hurt all the time. Just pick up a newspaper or turn on the news," Dr Concannon said, noting that as widespread as news coverage of gun injuries is, the media rarely reports injuries resulting from suicide and depression.

Dr Concannon says physicians need to stress to patients that guns are very destructive--more likely to be lethal than any other weapon. Suicides by drug overdose, carbon monoxide and self mutilation are far less likely to be successful than suicide by gun.

"So, therefore, doing something in the aftermath of a tragedy is ineffective. That's why you have to be proactive," he concluded. Dr Concannon recommends that physicians interested in finding out more about talking to patients about gun violence should contact the Center for Handgun Violence (PO Box 425, Bladensburg, MD 20710-9974) and obtain an audiotape called STOP--Steps to prevent firearm injury. (One side offers insight by former Surgeon General C. Everett Koop, MD, while the other side of the tape provides examples of physician-patient conversations on gun safety.)

When questioning parents and children about gun safety, many doctors like Dr Roberts have found it works best to slip the questions in with inquiries on bike helmets and water safety, simply by inquiring, "Are there guns in the house?" Then if yes, following up with questions about accessibility and information on gun locks and gun safes.

For adults without children, Dr Roberts uses a slightly different tact, asking adult males about personal safety habits--if they wear seatbelts; drink alcohol and drive; or keep guns

at home.

For women, the Belleville family physician begins by asking about arguments and conflict resolution. "Everyone argues. Are you ever afraid for your safety (when you and your spouse argue)? What do you fear happening? Are there guns at home?"

Susan Torhorst, MD, of Madison, says she asks gun safety questions during patient physicals but doesn't find there is really the time to get into the subject during shorter office visits. The family physician says the response she has received to her inquiries about guns has been very positive, with most patients eagerly sharing their methods of securing their guns.

One area of concern she has found is that some women are aware guns are in the home but have no idea where the firearms are kept. In those cases, Dr Torhorst suggests they find out where the weapons are and determine if they are properly secured.

Bernie Micke, MD, practices in Madison and has been active, along with his wife, in increasing public awareness of gun safety. He also serves on the SMS Commission on Injury Prevention and Control. Dr Micke encourages physicians who are not yet talking about gun safety to slip those questions in along with inquiries about alcohol, smoking and seatbelts. He reminds his colleagues that grants for local gun safety projects are still available through the SMS. (Contact Don Lord, 1-800-362-9080.)

Dr Micke says that while his questions about guns have met with mixed responses, people are rarely offended. "Some people have strong feelings on the subject while others are willing to look at different alternatives," Dr Micke said, adding that either way he hasn't felt his questions threatened the physician-patient relationship.

When his patients report guns are present in their homes, Dr Micke suggests that they consider whether a gun is actually needed. He stresses to his patients that guns are more likely to be used for suicide than to protect them from criminals. He also reminds his patients that firearms are frequently stolen and if not secured properly, their gun might one day be used to commit a crime. (According to the Bureau of Alcohol, Tobacco and Firearms, each year between 200,000 and 250,000 guns are stolen from U.S. homes.)

Dr Micke reports that he hit pay dirt at least one occasion when a patient decided to give up a gun. "That's not a resounding victory, I know," he said wryly.

But if you consider the recent carnage on the Chapel Hill, NC, campus where one student killed and wounded numerous others, it's apparent that even one gun in the wrong hands can do tremendous damage.

Dr Micke noted that he has begun talking to parents about looking into security at the homes where their children play. It doesn't do much good to lock up all your guns at home and then send your children off to play in a house where gun safety is not respected. Most parents, Dr Micke said, are taken off guard when that question is raised. It's a safety question they just never considered.

The process of learning how to talk to patients about gun safety has been compared by many physicians as being similar to that of learning to ask about seatbelt use, alcohol consumption, domestic abuse and other health risks. In the beginning, some physicians had to write notes to themselves to remember to discuss those issues. But in a short time, the questions became more automatic and they found conversations about

Continued on next page

Some guidelines for talking about gun safety

Murray L. Katcher, MD, PhD

Keep the message simple

- A gun is the most dangerous product in the home.
- Guns and ammunition should be made inaccessible (especially to minors).
- If you keep a gun, empty it out and lock it up.

Say it with style

- Be nonjudgmental.
- Avoid political controversy; keep it a health issue.
- Be a good listener and a good advisor. Respond with sensitivity.

Messages for parents

- Consider making your home gun free (especially if there is a person with depression, aggressive behavior or suicidal thoughts.)
- Guns are the most dangerous consumer products and should be locked up, just as poisons are.
- Bullets should be locked and stored in a place separate from the gun.❖

Continued from preceding page
those issues were just as easy as talking about other health topics.

Placing SMS brochures, posters and coupons for trigger locks in your waiting room is one way to begin talking about gun safety with your patients. (Talk with your field representative if you would like more information.) Or you can start, as at least one doctor did, with educating your friends about the need for trigger locks on their unsecured guns. Then work it into your medical practice.

Some doctors go beyond their office walls to get the message across. In Janesville, the county medical society launched a full-scale public health campaign with billboards and brochures under the direction of David Murdy, MD. By creating a community coalition, Murdy said the CMS was able to increase their resources for the project 7 to 8-fold. Janesville doctors partnered with the Beloit Families for a Safer Community and the Janesville Fathers for a Safer Community.

The public awareness campaign, Dr Murdy explained, helped them target a group that typically doesn't see physicians--young males--who may or may not have children in the home and are at risk for gun injury and improper gun use. The Janesville physician group intends to make the campaign more specific to gun-owning families in 1995 in efforts to further reduce tragedies.

Wisconsin physicians have found many ways to get their safety message across. Michael Pace, MD, of La Crosse, has been active talking to civic clubs. Several other La Crosse physicians including Marla Markham, MD, an emergency room physician, dermatologist Steve Webster, and Edward Miner, MD, an internist, took their gun safety message to the La Crosse mall, diving into the crowd to talk about this important issue with shoppers.

Dane Country physicians sent letters home to parents on gun safety, working through the school system. Chippewa Falls is providing their gun safety officer with public health materials for the next three years. Everin Hockom, MD, spearheaded an effort in Park Falls, where they gave out more than 150 trigger locks.

The methods are as limitless as your imagination. You will never know how many lives you may have saved or how many kids you kept from being injured. The success rate is immeasurable.

But you will know how many lives you won't influence, how many kids you won't save if you don't try.◆

National violence prevention programs and organizations

ABA Legal Solutions to Gun Violence Project
American Bar Association
1800 M Street, NW, 2nd Floor South
Washington, DC 20036-5886
Bruce Nicholson
202-331-2685

Coalition to Stop Gun Violence
100 Maryland Avenue, NE
Washington, DC 20002
202-544-7190

Handgun Epidemic Lowering Plan (HELP) Network
(Provides resources for physicians on firearm violence prevention)
2300 Children's Plaza, #88
Chicago, IL 60614
312-880-3826

National Center for Injury Prevention and Control
(Youth Violence Prevention Demonstration Programs)
Centers for Disease Control
Mail Stop MSK60
4770 Buford Highway
Atlanta, GA 30341
Timothy Thornton, Public Health Advisor
404-488-4646

National Crime Prevention Council
1700 K Street, NW
Washington, DC 20006
(Attention Faye S. Warren)
202-466-6272, ext 126

Steps to Prevent Firearm Injury (STOP)
(A Partnership Program between the American Academy of Pediatrics and the Center to Prevent Handgun Violence)
Center to Prevent Handgun Violence
1225 Eye Street, NW, suite 1100
Washington , DC 20005
Ricky O'Kane, Health Education Coordinator
202-289-7319

Straight Talk About Risks (STAR) Program
Education Division
Center to Prevent Handgun Violence
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PRESENTED HERE FOR YOUR consideration is the executive summary of the proposed SMS strategic plan update. The strategic plan was drafted by the SMS Strategic Planning Committee and approved by the SMS Board of Directors. It will be submitted to the full House of Delegates at the SMS annual meeting in April. SMS members are encouraged to review the summary and discuss it with their SMS delegates.

Highlights of the plan include a revised mission statement and four priority objectives. The proposed mission statement reads:

> The purpose of the Society is to: advance the science and art of medicine and the health of the people of Wisconsin; ensure that physicians are equipped to deal effectively with the economic and political aspects of practice; and serve as the patient and physician advocate to government and other relevant publics.

The four priority objectives are:

- *Physician and patient advocacy.* Expand SMS patient and physician advocacy beyond its traditional governmental focus to include monitoring, assessing and influencing the quality, accessibility and delivery of care as influenced by managed care and other entities.
- *Member-SMS two-way communication.* Enhance SMS position as *the* source of choice for health care information in Wisconsin, explore and promote the use of innovative communications technology and increase opportunities for physician feedback and guidance to SMS.
- *Member involvement.* Increase member's meaningful involvement in SMS activities with emphasis on balanced participation of member constituencies.
- *Practice management.* Educate, support and advocate for members in the area of practice management.

Strategic Plan Executive Summary

Background and overview

The State Medical Society of Wisconsin (SMS) developed strategic plans in January 1988 and again in February 1991. The strategic planning effort in 1994 is intended to build on the Society's previous efforts, incorporate the findings from recent member research and address changes in health care delivery systems and physician practice settings and patterns.

The 1994 planning process was initiated with a facilitated half-day session with the SMS Board of

Continued on next page

Directors and representatives of staff July 16 in Manitowoc. The purpose of this session was to involve the full Board in the process of analyzing the Society's current situation, responding to and documenting assumptions about the future.

The Strategic Planning Committee met in Lake Geneva Sept 16-18 tocontinue the planning effort and to recommend priority objectives to the Board for action.

The process utilized for both the July and September meetings involved a professional facilitator who guided both groups through their agendas. These agendas included the topics and issues that are required to make sound decisions and develop effective plans. The participants in the workshops provided the perspectives, opinions, and other information that served as the basis for the resulting plan. The complete transcriptions of these sessions are available as background information.

Current situation

The SMS has 8,000 physician members from a potential membership of approximately 11,000 physicians in the state. The SMS and its related entities operates on a consolidated annual budget of $9.3 million and is administered by a staff of 99.

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Recent history

The 1970s were marked by the early years of Medicare and Medicaid, the liability insurance crisis, the emergence of HMOs, considerable growth in the number of physicians, a growing percentage of women graduates from medical school, an increase in the size of group practices, the growth in the percentage of specialists and sub-specialists, and acceleration in technological advances.

In the 1980s, insurance companies and government increased influence over health care delivery, business coalitions became active in response to increased health care costs, reimbursement patterns changed, physician image deteriorated, an erosion in idealism and altruism among physicians as medicine became a business, non-hospital delivery of health care expanded, state medical societies' emphasis changed from scientific to socioeconomic, AMA membership began a decade-long decline, patient expectations increased, patients became more political about their health care concerns, non-physician providers of health care encroached upon the traditional physician's scope of practice, and the medical administrator position emerged within groups.

Mission

The current mission statement:

> The purpose of the Society is to bring together the physicians of the state of Wisconsin, to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws.

The proposed mission statement:

> The purpose of the Society is to: advance the science and art ofmedicine and the health of the people of Wisconsin; ensure that physicians are equipped to deal effectively with the economic and political aspects of practice; and serve as the patient and physician advocate to government and other relevant publics.

Situation analysis

The Strategic Planning Committee identified the following as organizational strengths: SMS membership and the high penetration of the potential member market; SMS extensive array of programs and services; the Society's stable financial position; the care and concern of physicians for patients; SMS staff; and the level of service delivery to individual members.

Weaknesses or areas requiring improvement that were identified by the committee include: under-representation of some member segments in the Society's leadership; the dependence on a small core of involved volunteers for Society leadership; the ability to reach consensus in a timely manner given the size of the Board and the diversity of member interests; time pressures on volunteer physicians and the effects on their participation; the perception that staff is too visible; and the use of many services by a declining percentage of members.

In brainstorming responses to the strengths and weaknesses of the organization, a variety of responses and suggested solutions were identified and considered.

The situation analysis also included discussions of characteristics of other state medical societies; a review of SMS current programs, services, products and activities; analysis of physician member market segments; and a review of SMS finances, organization, and culture. In addition, alternative organizations and competitive factors were evaluated, the effects of government reviewed and critical exposures were analyzed.

Assumptions

"Assumptions" are temporary estimates regarding important probable developments which cannot be predicted with accuracy and over which SMS has no significant control. They should not be considered forecasts or predictions, but they do reflect the current thinking of the group.

The following assumptions were developed in the July and September workshops:*Future profile and characteristics of the physician.* It is assumed that physicians will be more adept at using technology and information, increasingly female, somewhat younger and with some increase in the percentage of minorities. Fewer physicians will be self-employed, with more physicians in part-time or shared practices. The practice of medicine will be perceived as more of a job rather than a profession with members emphasizing quality-of-life issues.

Physician practice settings and patterns. There will be an increase in integrated systems and more niche or "boutique" practices. There will be an increase in practice parameters, and expanded use of integrated information systems and technology.

Environment in health care and health care delivery systems. It is assumed that there will be horizontal and vertical integration of health care delivery, with the majority of the population capitated. Patients will have less personal choice and there will be more managed care and care based on populations. Access to medical services will be based on economics. Clinical trials will take on increased importance. There will be an increased use of data. Regulation will increase.

The centers of influence in health care changes are anticipated to be those who control data. Payors (big business, government and insurance companies) will have influence and consumers will exert influence through the political system.

Assumptions regarding SMS. It is assumed that SMS will continue to be a "player." The Society will continue to be responsive and adaptable and pay increased attention to providing value for dues. The SMS will remain an organization of individual physicians. The Society will encounter resource constraints from traditional sources and will also encounter difficulties in reaching consensus. "Hot" members will increasingly challenge SMS decisions and positions. It is anticipated that there will be a continuing shift of activities and services from AMA to SMS.

Continued on next page

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Continued from preceding page

Initial objectives

The following objectives were initially established by the Strategic Planning Committee. They were ranked using a forced choice system and are presented below in descending order of priority:

1. Ensure that physicians are active players in decisions regarding patient care.
2. Represent physician and patient goals to decision-making bodies.
3. Improve communication of the value of SMS membership to each member segment.
4. Improve communication to member physicians in our three major spheres of activity (political, scientific, socioeconomic).
5. Increase member approval rating from 85% "good/excellent" to 90% by 1997 by making sure that SMS services and activities are aligned with member needs and interests.
6. Evaluate the structure of the SMS governance to ensure that it remains responsive and representative.
7. Position SMS as the organization that efficiently determines the health care goals of physicians and patients.
8. Maximize physician influence in the emerging integrated systems.
9. Develop new ways for more members to participate in SMS activities.
10. Interpret and facilitate the implementation of decisions made regarding physicians and patients.
11. Increase resident and young physician involvement in SMS.
12. Ensure appropriate physician security and just compensation.
13. Maintain the Society's sound financial position by increased attention to cost/benefit analysis of services and activities.
14. Penetrate hospital staff and large group staff meetings as an alternative conduit to county medical societies.
15. Evaluate the status of unified counties with the State Medical Society.
16. Be the identified source and controller of outcome data in Wisconsin.

Consolidated and revised objectives

The Strategic Planning Committee analyzed the above objectives and consolidated them into four priority objectives by combining similar objectives and eliminating duplication among the initial objectives.

- *Physician and patient advocacy.* Expand SMS patient and physician advocacy beyond its traditional governmental focus to include monitoring, assessing and influencing the quality, accessibility and delivery of care as influenced by managed care and other entities.
- *Member-SMS two-way communication.* Enhance SMS position as *the* source of choice for health care information in Wisconsin, explore and promote the use of innovative communications technology and increase opportunities for physician feedback and guidance to SMS.
- *Member involvement.* Increase member's meaningful involvement in SMS activities with emphasis on balanced participation of member constituencies.
- *Practice management.* Educate, support and advocate for members in the area of practice management.

The Strategic Planning Committee further developed the above strategic priorities by documenting additional, specific assumptions and premises that underlay each priority. In addition, to clarify each objective, specific criteria for success were established for accomplishment by 1997.

- *Physician and patient advocacy.*
  - I. Additional, specific assumptions and premises
    - a. There is a need and SMS best fulfills this role.
    - b. The Commission on Health Care Financing and Delivery is responsible for this area.
    - c. SMS attorneys and staff have addressed individual situations.
    - d. It is difficult to document or verify controversial situations.
    - e. Large groups often address these situations independently of SMS.
    - f. Typical issues: reimbursement, length of stay, approved procedures and medications.
    - g. There is a need for better collaboration between SMS and specialty societies.
    - h. We need to build on existing policies (for instance: our endorsement of AMCRA quality review voluntary guidelines).
    - i. There will be ties to our government relations initiatives.
    - j. Additional resources will be required if activity is substantially increased.
    - k. Situations will be communicated to SMS through physician members.
  - II. Criteria for success--1997
    - a. An established mechanism to respond to physician and patient complaints.

b. Maintain a data base to monitor complaints, resolutions, and trends.
c. Educate members on the program.
d. Win one or two.

- *Member-SMS two-way communication*

I. Additional, specific assumptions and premises
a. Members will have an increasing array of communications available to them.
b. We are currently well positioned as a source.
c. Most communications are SMS to members.
d. Conduits to improve member suggestions or feedback are available through visits to physician lounges, clinic meetings, hospital medical staffmeetings, and county society and specialty society meetings.
e. A means to stimulating member feedback is to present them with information or an issue for their reaction.
f. Members will increasingly use communications technology, but we have a long way to go. We will attempt pilot or test efforts.
g. Communications technologies may be a way to engage young physicians.
h. We will encounter significant resistance to changes to traditional communications methods.
i. We will have to run parallel communications systems to meet varying member preferences.
j. We can use the Executive Committee and Board to test electronic communications.
k. Our traditional communications vehicles are becoming less effective, in part due to general information overload.
l. Reformatting may be helpful. People want concise information with opportunities for more information or detail.
m. We need to communicate the value of SMS and the benefits of supporting the society.

II. Criteria for success--1997
a. Test using the Executive Committee and Board to communicate electronically.
b. Develop capability to survey member segments--shorter surveys and other quick feedback vehicles.
c. Reformat and streamline SMS communications.
d. Mount a campaign to continually reinforce what SMS does and its value to members.

- *Member involvement.*

I. Additional, specific assumptions and premises
a. It will be increasingly difficult to get the time of members given traditional approaches.
b. Members believe that there are adequate opportunities for involvement (92% in 1994 surveys).
c. We need to better understand why members get involved.
d. We will investigate alternative mechanisms for participation.
e. We can investigate increased use of task forces and ad hoc teams to address issues.
f. There are opportunities to expand the use of conference calls v traditional meetings.
g. Some answers will come from use of technology.
h. Meeting locations need to be evaluated for member access.
i. We need to evaluate frequency of meetings.
j. There are currently voids or under representation in the following physician seg-

Continued on next page

Family Medicine • Cardiology
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Continued from preceding page

ments: women, young and new, IMGs, cultural and ethnic minorities.

II. Criteria for success--1997
   a. Commission and task force membership increasingly corresponds with membership demographics.
   b. Full participation in the House of Delegates.
   c. Evaluate the allocation of board seats to under-represented segments.
   d. Initiate discussions regarding the society's governance in the 21st century.

- *Practice management.*

I. Additional, specific assumptions and premises
   a. Physicians increasingly need help to understand the financial implications of changes in the health care industry.
   b. Physicians are uncertain as to whom to turn. Many do see SMS as a source of assistance.
   c. External factors will continue to reshape the economics of practice.
   d. An increasing number of physicians will require job counseling services and practice management assistance.
   e. We need to communicate what is happening out there, and much of it is not positive news. Communicate what realistic options physicians have.
   f. We can get the information across in a positive way, yet communicate the realities of the market place.
   g. Case study information has not been easy to acquire.

II. Criteria for success--1997
   a. Position the SMS as the source for practice management assistance.
   b. Better identify the practice management needs by segment.
   c. Increase member awareness of market realities and their options and creative alternatives.
   d. Package existing services more effectively.

In addition to the above consolidated priority objectives, the Strategic Planning Committee reconfirmed the Society's commitment to sustaining existing programs and services as long as they are relevant, used and worthy of the resources required to support them (a list is attached as Appendix).

Action plans (which identify specific tasks or projects, establish time lines and identify resources required) for each priority objective will be developed within 6 months of board action on the proposed strategic plan.

The Executive Committee will be responsible for monitoring plan implementation.

Appendix

Publications

- *Capitol Update*
- *Focus*
- Interprofessional code
- Legislative directory
- Legislative issues booklet
- *Medical Times*
- *Medigram*
- *Physician's Guide to Wisconsin Health Law*
- *Policy Compendium*
- *A Practical Guide to Public Relations*
- *the Board Report*
- *Wisconsin Medical Journal*
- *Service Line* (SMS Holdings newsletter)

Programs

- Annual meeting
- Charitable, Educational and Scientific Foundation
  - -- Beaumont 500 Club
  - -- Endowment Plus life insurance
  - -- Fort Crawford Medical Museum
  - -- Golf Classic
  - -- Memorial giving program
  - -- Physicians' benevolent fund
  - -- Pooled income fund
  - -- Scholarship program
  - -- Student loan program
  - -- Voluntary contributions
- CME accreditation
- District caucuses
- Endorsed programs
  - -- Auto rental (Avis, Hertz)
  - -- Credit cards (Elan)
  - -- Debt collection (I. C. System)
  - -- Medical equipment financing (Bell Atlantic Tri Con)
- 50 Year Club
- House of Delegates
- Key contact system
- Medical business specialist certificate program
- Medical Outcomes Research Project
- New leadership orientation program
- PartnerCare
- Physicians for Better Government

- Physician Support ProgramPolitical action programs
- Resident mentor program
- Scientific symposium
- Seminars program, practice management
- Statewide Physician Health Program
- *Wisconsin Care*
- WISPAC
- Workshop on Health

Services
- Advertising (*WMJ*)
- Bylaws--CMS
- CPT-4, ICD-9CM consulting
- Ethical opinions
- Group Practice Section
- Hospital Medical Staff Section
- International Medical Graduates Section
- Legal services (eg, contract review)
- Legislation and regulation representation and advocacy
- Managed care credentialing project
- Media relations
- Mediation and peer review
- Medical legal information system
- Medical Student Section
- Medicare policy and procedures
- Meeting services and special events planning
- Mini-internship programs
- Outreach services
- Patient edueation brochures
- Physician education materials
- Public relations
- Research services
- Resident Physician Section
- Senior Physicians, Wisconsin Association of
- Speaker's bureau
- Speech, letter and editorial writing services
- Third-party payment services
- Toll-free hotline
- Travel packages (eg, INTRAV)
- Young Physician's Section

(SMS Holdings)
- Association management services (Lakeside Association Services, Inc.)
- Employee benefit consulting services (Member Benefit Services, Inc.)
- Estate planning
- Printing and copying services (Lakedge Printing)
- Third party insurance administration (Lakeside Administrators, Inc.)

Products
- Medicare Part B physician handbook
- Membership labels
- Occupational Health Guide
- Practice management resources handbooks

(SMS Holdings)
- HCFA 1500 claim forms
- Medicare disclosure forms A & B
- Return to work recommendation form
- SMS Insurance, Inc. products
  - -- Dental insurance (Delta Dental)
  - -- Disability (Paul Revere)
  - -- Health Insurance (WPS)
  - -- Life Insurance (Northwestern National Life)
  - -- Medical professional liability insurance (PIC Wisconsin and WHCLIP)
  - -- Professional Office Policy (POP)
  - -- Workers' Compensation (Dodson)❖

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Nominees for SMS offices: 1995-1996

Richard H. Ulmer, MD

Sandra L. Osborn, MD

John D. Riesch, MD

Richard H. Ulmer, MD
Nominated for president-elect for 1995-1996

Dr Ulmer received his MD and MS in physiology from Stritch School of Medicine of Loyola University, Chicago. He served his internship and residency in cardiology at the University of Chicago Hospital and Clinics. He is a cardiologist at the Marshfield Clinic. Dr Ulmer was president of the Wood County Medical Society in 1978 and 1985. He has been chair of the SMS Board of Directors since 1989 and was a member of the AMA Forum for Employed Physicians and its successor, the AMA Advisory Committee on Group Practice Physicians. He is also a member of the SMS Committee for Young Physicians. He was an alternate delegate to the AMA for ten years, and was elected delegate to the AMA in 1994.

Sandra L. Osborn, MD
Nominated for speaker of the House of Delegates for 1995-1997

Dr Osborn, whose specialty is pediatrics, graduated from the University of Wisconsin Medical School in Madison. She was a member of the SMS Board of Directors representing District 2 from 1987 to 1994. She is a member of the WISPAC Board of Directors and co-chair of the SMS/WNA Committee. Dr Osborn served as president of the Dane County Medical Society from 1982 to 1983. She has also served as chair of the House of Delegates Nominating Committee, the Credentials Committee and the Reference Committee on Scientific Affairs. Dr Osborn also served on the Ad Hoc Committee on Child Abuse and Neglect and the SMS Committee on Women Physicians.

John D. Riesch, MD
Nominated for delegate to the AMA for 1996-1997

Dr Riesch graduated from the University of Wisconsin Medical School in 1958. He served his internship and residency at Milwaukee County General Hospital and is assistant clinical professor of surgery at the Medical College of Wisconsin. He served as president of the Waukesha County Medical Society in 1973-1974 and president of the Waukesha Cancer Society in 1969-1970. Dr Riesch was a member of the SMS Commission on Mediation and Peer Review and serves on the House of Delegates Nominating Committee. He is an SMS delegate from Waukesha County and serves as chair of the Ethics Committee of the State Surgical Society. He is also a past president of the Milwaukee Academy of Surgeons.

Kenneth M. Viste, Jr., MD
Nominated for delegate to the AMA for 1996-1997

Dr Viste was president of the SMS in 1987-1988. He was chair of an SMS reference committee in 1978, a member of the SMS Board of Directors since 1982, chair of WISPAC from 1978 to 1980, and chairman of the task force that developed Wisconsin Care in 1993. He also chaired the Rural Health Task Force in 1988. Dr Viste was a member of the nominating committee from 1978 to 1985 and chairman in 1984. He was chairman of the Physicians Alliance Commission from 1978 to 1985. He

Continued on next page

Kenneth M. Viste, Jr., MD

Kevin T. Flaherty, MD

Robert J. Jaeger, MD

has been president of the Wisconsin Neurologic Society and the Northwestern University Medical School Alumni Association and currently is president elect of the American Academy of Neurology. He hasserved on the AMA Council on Legislation since 1988 and is currently chairman. He was appointed by Secretary Shalala and currently serves on the Practicing Physicians Advisory Council of HICFA. He has also been a member of the Medical Examining Board of the Department of License and Registration. He was appointed by Governor Lucey as a member of the Health Policy and Planning Council and was appointed by Governor Thompson to serve on the Rural Health Development Council. Dr Viste is a native of Sturgeon Bay, Wisconsin, and did his medical school and residency training at Northwestern University Medical School in Chicago.

Kevin T. Flaherty, MD
Nominated for alternate delegate to the AMA for 1996 and 1997

Dr Flaherty received his medical degree from Loyola University in Chicago. He served an internship at Sacred Heart Medical Center in Spokane, Wash, and his residency at Loyola University in ophthalmology. He has been in practice in Wausau for 6 years. Dr Flaherty has served as the Marathon County Medical Society delegate to the SMS House of Delegates. He has also been a member of the Marathon County Medical Society Executive Committee and president elect. He has chaired reference committees at the Young Physicians Section of the AMA and SMS.

Robert J. Jaeger, MD
Nominated for alternate delegate to the AMA for 1996 and 1997

Dr Jaeger is a specialist in obstetrics and gynecology. He attended the University of Wisconsin Medical School and served an internship and residency at Milwaukee County General Hospital. Dr Jaeger is an assistant clinical professor in the Department of Obstetrics and Gynecology at the Medical College of Wisconsin and serves on the board of directors of the University of Wisconsin medical Alumni Association. He has served on the SMS Board of Directors since 1988 and is currently a member of the SMS Commission on Maternal and Child Health and the Maternal Mortality Committee. Dr Jaeger is a member of the board of directors for the Portage County Medical Society as well as an alternate delegate. He is president of the Wisconsin Society of OB/GYN and chairman of the Wisconsin Section of the American College of Obstetrics and Gynecology.

Susan L. Turney, MD
Nominated for delegate to the AMA for 1996 and 1997

Dr Turney received her medical degree from the University of Wisconsin. She served her internship and residency at St. Joseph's Hospital/Marshfield Clinic. She has been in general internal medicine at the Marshfield Clinic since 1982. Dr Turney served as an alternate delegate to the AMA since 1993. She was president-elect of the Young physician section of the SMS from 1992-1993. She served on the SMS Physicians Alliance Commission, Reference committee on socioeconomic activities, Reference Committee on Health Care System Reform, Commission on Female Physicians, Task Force on Physician Manpower, and Health Care Financing and Delivery Committee. She has been co-chair of the Medicare Carrier's Advisory Committee since 1992. She is presently a delegate to the American Society of Internal Medicine.
Paul J. Leehey, III, MD

Susan L. Turney, MD

Paul J. Leehey, III, MD

Harry J. Zemel, MD

If Susan L. Turney, MD, is elected by the 1995 House of Delegates as an AMA Delegate, the committee is prepared to nominate **Paul J. Leehey, III, MD,** La Crosse, as an AMA alternate delegate for calendar years 1995, 1996, and 1997.

Dr Leehey received his medical degree from the University of Iowa. He served a residency in diagnostic radiology at Cook County Hospital, Chicago. He served a CT/US fellowship at Wayne State University, Detroit, Michigan. Dr Leehey has been a diagnostic radiologist at Gundersen Clinic in La Crosse since 1990, and has been head of the CT Section since 1991. He is president of the La Crosse County Medical Society and has been an alternate delegate to the SMS since 1992. He also serves as a delegate to the Young Physicians Section of the AMA.

Harry J. Zemel, MD
Nominated for Treasurer for 1995-1996

Dr Zemel was first elected to the Board in 1987. He graduated from the University of Missouri School of Medicine and specializes in pathology. Dr Zemel was president of the Fond du Lac County Medical Society in 1979, chair of the Finance Committee since 1989, and was elected Treasurer in both 1993 and 1994. Currently Dr Zemel serves on the Finance and Investment Committees for the College of American Pathologists.◆

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First in a series

Practical considerations regarding ethical questions in the daily practice of medicine

THE CHARGE OF the State Medical Society's Commission on Medicine and Ethics states, in part, that the Commission "...shall be concerned with the ethical aspects of medical practice in order to permit discussion of common problems in the total treatment and care of patients." In keeping with this charge the commission, chaired by J D Kabler, MD, has decided to undertake a series of articles that discuss questions and problems which relate to the daily practice of medicine.

The first question discussed by the commission relates to either impairment or incompetence of a physician. Both the AMA and the SMS have policies regarding these issues. The AMA states that with regard to impairment:

It should be reported to the hospital's in-house impairment program, if available. Otherwise, either the chief of an appropriate clinical service or the chief of the hospital staff should be alerted. Reports may also be made directly to an external impaired physicians program. Practicing physicians who do not have hospital privileges should be reported directly to an impaired physicians program. If none of these steps would facilitate the entrance of the impaired physician into an impairment program then the impaired physician should be reported directly to the state licensing board.

With regard to incompetence, the AMA states:

Initial reports of incompetence should be made to the appropriate clinical authority who would be empowered to assess the potential impact on patient welfare and to facilitate remedial action. The hospital peer review body should be notified where appropriate.

Incompetence which poses an immediate threat to the health of patients should be reported directly to the state licensing board. Incompetence by physicians without a hospital affiliation should be reported to the local or state medical society.

The SMS also has policy on impairment situations. It supports guidelines that stress early recognition of physician impairment problems in the hospital and provide for effective and compassionate guidance in resolving impairment situations with counsel from the statewide Impaired Physician Program as required.

While guidelines and policies are in effect, members of the commission found that in actual daily practice, cases involving physician impairment or incompetence are never easily resolved.

Question 1

A physician is aware that another physician has problems with forgetfulness and personal grooming which affect that physician's ability to properly treat patients. What are the physicians' ethical responsibilities?

Members of the commission agreed that methods for dealing with this kind of problem exist in most hospitals. Several physicians described their personal responsibility in this situation and gave it a top priority. They thought as did Steven H. Cohen, MD, that the "first step is to discuss the problem with the physician. If no satisfaction is noted, discussions with department chair, staff president, medical society representatives can be considered." Philip J. Douherty, MD, believes that referral to members of the impaired physicians family (for example, the spouse or adult children) might be appropriate.

Kathryn P. Nichol, MD, noted that she "would separate a physician's forgetfulness from the physician's personal grooming." She went to say that, "there are different standards for different people and unless the personal grooming was something that would impact infection control, etc., that should not be dealt with by another physician." Dr Nichol thought that talking with other physicians who interacted with the physician in question was a good idea and it was the consensus of the commission that a small group of peers could more effectively deal with the problem than a single individual.

Physicians who don't work in a hospital setting may see things differently. Armond H. Start, MD, while agreeing that he would (in the case of a trusted associate) go first to the physician in question, feels that his next step would be to notify the State Medical Society or medical licensure committee that are set up to deal with impaired physicians.

The question of the difficulty of confronting colleagues who are thought to be impaired was addressed. Commission members agreed that intervention was not done as often as it should be and that problems were almost always dealt with too late rather than too soon. This was due mostly to the natural inclination to give people a "second chance" as well as what William J. Listwan, MD, describes as the probability that "this would very likely result in significant publicity and there is no doubt in my mind that

the involved physician would know who had "aimed the gun" at him." Dr Listwan noted that often this becomes a "contentious situation with bad publicity for the physician involved, whether deserved or not."

While recognizing the hesitance that often goes along with situations of physician impairment or incompetence, commission members agreed that the first consideration should be patient well-being. Charles Gessert, MD, notes that "the act" of noticing impairment changes our status; we become partially liable (morally, if not legally) for subsequent harm that results from inaction." Dr Gessert also thought the situation illustrates a responsibility that physicians have to their profession. "The impaired individual erodes public confidence, not only for himself or herself, but for the profession. To the degree that medicine fails to keep its own house in order, through internal corrective actions, it invites external sanctions."

While the actions of a physician who becomes aware of another physicians impairment might vary somewhat, his responsibility remains clear. Members of the Commission on Medicine and Ethics suggest that since these situations are never easily resolved, the dual principals of "firm kindness" and "kind firmness" serve as a guide.

Question 2

The majority of a physician's patients are covered by a health plan that recently instituted its own set of "practice parameters" that must be followed by physicians continuing to participate in the plan. Among these parameters are limitations on treatment length and length of hospital stay that their physician feels are questionable or dangerous. What is the physician's ethical responsibility? Is it ethically acceptable to follow the guidelines imposed while seeking changes?

The AMA policy regarding this issue states that "While physicians should be conscious of costs and not provide or prescribe unnecessary services or ancillary facilities, social policy expects that concern for the care the patient receives will be the physician's first consideration."

Members of the commission once again regarded their responsibility to their patient's care as an ethical imperative. Steven H. Cohen, MD, noted that "Managers and administrators of medical plans are not licensed to treat patients and are not willing to be held accountable for medical malpractice. Therefore, the decision as to the length or appropriateness of medical care must be made by the physician responsible for the patient. If a physician disagrees with a practice guideline, he needs to document the name and position of the individual limiting care in the patient's chart. This is for his knowledge as well as for the patient and the patient's family. The next step, if approval for treatment is not forthcoming, is to proceed up the chain of responsibility, documenting each contact by name and location, until the limitations are lifted so that proper care can be given."

Kathryn P. Nichol, MD, agreed and added that she was "not aware that practice parameters even under health plans have clauses where physicians "must" follow it." She went on to say, "I think most practice parameters are set up so that if a

Continued on next page

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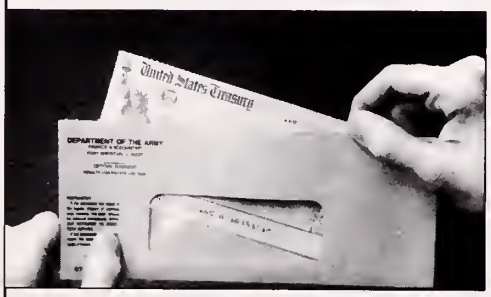

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recommended guideline is deviated from, it is highly encouraged that there be rationale for the deviation. That is the only way that physicians should accept and embrace practice parameters."

While members of the commission were all intent on serving their patients, best interests, several physicians felt that the issue was perhaps more complicated than a first appraisal might indicate. William J. Listwan, MD, states that, "Many of the "hassles" (of managed care) are not life and death--they're just a matter of opinion." He went on to note that many physicians resent having the decisions limited or taken away from them. Dr Listwan felt that consultation with the patient regarding the practice parameters and their impact on the patient's treatment would be advisable. It was his feeling that a concerted effort on the part of both the physician and the patient would lead to a more suitable outcome. He did note though, that "if the patient was unwilling to do so, I might have an obligation to do so for them."

Charles Gessert, MD, agreed with Dr Listwan regarding the complexity of this issue. In his view, the possible benefit to the individual must be weighed against the possible cost and consequences to society as a whole. Dr Gessert believes that physicians must take a leadership role in determining the medical benefits offered by health plans such as the one described in this scenario. It's his feeling that physicians "must avoid taking the position that medical services have a "trump" value in the resource allocation process." He goes on to state that physicians "should be guided by the recognition that good resource allocation decision-making within health care must develop before health care can argue for a larger share of the society's resources."

The issues brought forth in this second vignette point to the difficulty faced not only by physicians but by our society as a whole. Resource allocation remains an ethical dilemma. Performing a costly procedure on a single individual may benefit that person. But it will also consume limited resources that could have provided more benefits to a large number of people. Sometimes the limits constructed by a managed care plan are petty and bureaucratic. At other times though, they set a standard for a societal ethic on the cost:benefit ratio of care.

Note from the chair

The opinions expressed by members of the commission regarding the ethical dilemmas posed in this article are not to be construed as the policy of the SMS. They are simply opinions. The commission urges physicians reading this article to consider these situations and offer their own perspectives. Comments or suggestions for other ethical dilemmas the commission may consider are welcome and can be mailed to the Commission on Medicine and Ethics at the State Medical Society of Wisconsin, PO Box 1109, Madison, WI 53701, or sent via FAX to (608) 283-5401.◆

Register now for 1995 SMS Legislative Day

SMS members may still register for the 1995 SMS Legislative Day. Attorney General Jim Doyle will be the keynote speaker at SMS Legislative Day, scheduled for March 14 at the Concourse Hotel in Madison. Other dignitaries participating in the legislative forum will include Carol Buettner (R-Oshkosh), chair of the Senate Health Committee; Senate Democratic Leader Bob Jauch (D-Poplar); Assembly Health Chair Gregg Underheim (R-Oshkosh); and Ann Haney from the Division of Health. The forum provides physicians with the opportunity to ensure state leaders have a true picture of medical practice and physician concerns.

Legislative Day will begin Tuesday, March 14, at 8:30 a.m. at the Concourse Hotel in Madison. The morning session will include remarks from powerful state leaders. After lunch, you will meet with your own elected representatives to discuss issues that are important to medicine. Lunch and refreshments will be provided. There is no fee to SMS members attending the conference. To register, call Judy Frey at (608) 257-6781.◆

A win in Minnesota

In a victory for Wisconsin physicians, the Minnesota Department of Revenue decided Jan 23 not to appeal the district court judgement which determined Minnesota could not collect a 2% tax on non-Minnesota health care providers. The SMS supported three Wisconsin physicians listed among plaintiffs in the lawsuit challenging the tax's constitutionality. ◆

SMS president urges health care workers to end nightmare of domestic violence

SMS PRESDIENT Richard G. Roberts, MD, JD, traveled to Fond du Lac recently to urge the medical community to play a stronger role in responding to escalating levels of violence in Wisconsin.

Dr Roberts did part of his training at a Santa Monica (Calif) hospital, one of the first sites in the nation to have a hospital-based advocacy program on domestic violence and praised the efforts being made in Fond du Lac to meet the needs of battered women here. He described for his Fond du Lac audience several tragedies he has witnessed during his medical practice.

Roberts cited the following statistics:

- 7,521 sexual assaults reported in Wisconsin in 1993, the latest year for which statistics are available;
- 30% were of the most despicable crimes--forcible rape, forcible sodomy or assault with an object; and
- 92% of all assaults were committed by someone known to the victim.

The medical society president noted that Wisconsin physicians are taking an increasing role in increasing public awareness of domestic violence and the are seeking to ensure that battered women are given the resources, the authority and the support to make the decisions in their lives.

Roberts said the SMS Board of Directors voted to approve the following policy at its February 1994 board meeting:

"It is of the utmost importance for Wisconsin physicians to recognize the prevalence of domestic violence in our state and assess patients for this abuse. In treating patients who are possible victims of domestic violence, the goal of intervention must be to help victims regain control of their lives. Therefore, it is vital that physicians pay great respect to a patient's right to not disclose domestic abuse or to refuse intervention when the patient believes such action is not in his or her best interest. The role of the physician in this process is to offer patients options and allow them to make the decisions in their lives. The patient's decision should be documented in the medical record.

Believing the violence in our society should be addressed at all levels, Dr Roberts has initiated during his presidency a statewide program on gun safety, urging parents to keep guns and ammunition locked away from their children as well as stressing the need for increased attention to means of peaceful conflict resolution. The public health program has been very successful. The medical society has given away nearly 10,000 trigger locks, working in concert with local physicians and public safety agencies.✦

AMA awards

The Wisconsin physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates members of the SMS.

* Billings, Kenneth J.
* Dodson, Vernon N.
Engber, William D.
* Kaupie, Robert C.
Loteyro, Corazon B.
* McGrath, Mary E.
* Meeter, Urquhart L.
Polacek, Michael A.
* Satory, John J.
* Sneed, Robert J.✦

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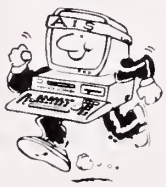

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County society news

Brown. The Brown County Medical Society approved membership for Lynn M.Budzak, MD.

Door-Kewaunee. Shaun J. Melarvie, MD, has been accepted into the Door-Kewaunee County Medical Society.

Eau Claire-Dunn-Pepin. The following physicians have been approved for membership in the Eau Claire-Dunn-Pepin County Medical Society: Charles D. Bantle, DO; Mark C. Bildsoe, MD; George A. Boush, MD; Daniel P. Burns, MD; Michael D. Erickson, MD; Jeffrey T. Goodwin, MD; Paul W. Green, MD; James S. Iwakiri, MD; Ronald J. Krajnik, MD; Robert L. Lazo, MD; Timothy L. Malling, MD; Michael Q. Milz, MD; William D. Morin, MD; John A. Odell, MD; Johann M. Peikert, MD; Deborah A. Raehl, DO; John S. Reidell, MD; George T. Ripeckyj, MD; David A. Van de Loo, MD; Peter J. Wagner, MD; Robert Forrest Watson, MD; A. Keith Wesley, MD; Michael R. Wolfson, MD; and George F. Woodington, MD.

Kenosha. The Kenosha County Medical Society approved membership for Dana R. Trotter, MD; Mary F. Schroeder-Capelli, MD; Ikram V. Rashid, MD; Ann Bell, MD; Regina Capelli-Scheidt, MD; John F. Gilligan, MD; and Ricardo E. Perez, MD.

Lincoln. Toni Almond, MD has been accepted into the Lincoln County Medical Society.

Manitowoc. The following physicians were elected to membership in the Manitowoc County Medical Society: Steven Chilinski, MD; Steven Driggers, MD; Lynn Holder, MD; and Abdul Chaudhry, MD.

Milwaukee. The following physicians have been approved for membership in the Milwaukee County Medical Society: Jerry R. Blair, MD; Cathie E. Dunal, MD; Michael R. Gallagher, MD; Mohammad Larijani,k MD; Nedal S. Mejalli, MD; and Aleksandar V. Milovanovic, MD.

Oneida-Vilas. The Oneida-Vilas County Medical Society approved membership for Eunice Corujo, MD; Diane M. Kretz, MD; and Alfred L. Neuhoff, MD.

Racine. The Racine County Medical Society approved membership for Marc F. Catalano, MD; Andrew J. Heritch, MD; and Gregory H. Pae, MD.

Richland. Allon H. Bostwick, MD, has been elected to membership in the Richland County Medical Society.

Rusk. Franklin H. Blackmer, Jr., MD, has been approved for membership in the Rusk County Medical Society.❖

SMS's CHILD SAFE initiative wins achievement award

THE CHILD SAFE gun safety initiative was recently selected to receive the 1995 Wisconsin Maternal and Child Health Achievement Award for Innovative Single Public Information Activity.

The MCH awards committee stated,"we believe you are deserving of the award for your contributions to improve maternal and child health in the state and exemplify the MCH Coalition statement: "Children are the future. The way we treat our children is reflected in everything we are as a society and in everything we will become." An awards luncheon will take place March 8 in Madison. CHILD SAFE will be entered into the National Healthy Mothers, Healthy Babies Coalition awards process.❖

Physician briefs

The * indicates a member of the SMS.

Gerard G. Adler, MD,* formerly of Marshfield, has joined the department of orthopaedic surgery at the Wilkinson Medical Clinics, SC, of Oconomowoc. Dr Adler received his degree from the UW Medical School and completed his training at the Grand Rapids Orthopaedic Surgery Residency in Michigan.

Paul Anselmo, MD, has joined the Oconto Memorial Hospital. He graduated from Gonzaga University, Spokane, Wash, in 1963 and received his medical degree from Marquette School of Medicine in Milwaukee in 1970. His postgraduate training included an internship at Barnes Hospital in St Louis, internal medicine at St Vincent Medical Center and the Los Angeles County OSC Program. Prior to joining Green Bay Health Care, he was in private practice in Newport Beach, Calif.

Brian Bozelka, MD, has joined the Physician's Clinic of Oconto Memorial Hospital. He is an ophthalmologist.

David Burnett, MD,* will be leaving a full-time practice with Reedsburg Physicians Group to become staff medical director for Wisconsin Physicians Service.

Abdul Chaudhry, MD,* has been named medical director at Royce C. Lin Memorial Dialysis Center, Inc., Manitowoc. Dr Chaudhry received his internal medicine training at St. Luke's Hospital and Washington University in St Louis, Mo. He served a nephrology fellowship at Vanderbilt University in Nashville, Tenn. He became board-certified in internal medicine in 1992.

Eunice Corujo, MD,* pediatrician, joined Rhinelander Medical Center, pediatric and adolescent medicine department. Dr Corujo earned her MD degree from the University of Puerto Rico School of Medicine. She completed a 3 year residency at San Juan City Hospital in 1989. She provided emergency room services to the San Jorge Pediatric Hospital in Santurce, Puerto Rico, and University Hospital in Bayamon, Puerto Rico, until 1992. She has been in public health service for the Indian Health Service Hospital in Fort Yates, ND, since 1992.

Mark A. Dorow, MD, has joined the medical practice of John P. Modzrynski and Michael H. Knautz. All three physicians are members of Covenant Medical Group. Dr Dorow earned his undergraduate degree in chemistry from the University of Wisconsin-Madison and his MD degree from the Medical College of Wisconsin. He then completed a one-year family practice internship and a two-year family practice residency program at the former Deaconess Hospital and Good Samaritan Medical Center.

Peter Fergus, MD,* has joined Oconto Memorial Hospital outpatient Physicians Clinic. Dr Fergus graduated from Harvard University in 1966, earned his medical degree at the University of Rochester School of Medicine and Dentistry in 1970, and did his internship and residency in internal medicine at Boston City Hospital in 1975. He completed his residency in cardiology at West Roxbury Veterans Administration Hospital. He has practiced cardiology in Green Bay since 1975.

W. Bruce Fye, MD,* a Marshfield Clinic cardiologist, was honored for his respected medical history research by receiving the 7th annual Gwen D. Sebold Research Fellowship. He was chosen by the Marshfield Medical Research Foundation Executive Committee to receive the $5,000 fellowship. Dr Fye is the official historian of the American College of Cardiology. He is one of the few clinician-historians in America with a degree in medical history. He serves as adjunct professor of the history of medicine and clinical professor of medicine for the University of Wisconsin-Madison. He has been chair of the clinic's cardiology department since 1981.

Donald Garland,MD, has joined the occupational health program of All Saints Medical Group, specializing in occupational injuries. Dr Garland was in private practice in Minneapolis before coming to Wisconsin. He received his medical degree from the University of Rochester School of Medicine.

Howard Hack, MD, has joined the medical staff of Milwaukee Medical Clinic, SC, specializing in gastroenterology. He received his medical degree from Washington University School of Medicine in 1988.

Ahmad Y. Haffar, MD,* recently opened Valley Neurology Clinic in Oshkosh and a satellite office at Ripon Medical Center. Dr Haffar is a board certified neurologist, and has been in private practice with Lakeside Neurocare Ltd. in Oshkosh for more than 14 years.

John Hanson, Jr, MD,* has joined the medical staffs of Hartford Memorial Hospital and the Hartford Parkview Clinic, as a hematologist. He earned his degree in medicine from Marquette University Medical School in 1964 and completed a hematology fellowship in medical oncology at Mount Sinai Hospital in New York.

Continued on next page

Continued from preceding page
Joseph O. Hoffman, MD, has joined the staff of the Mercy Walworth Medical Center. He received his medical degree from the Kirksville College of Osteopathic Medicine and completed his internship at Massachusetts Hospital in Boston.

Chazwan Katmeh, MD, has joined the staff of the Oconto Memorial Hospital as a cardiologist. He earned his medical degree from Aleppo University and Bagdad University in Bagdad, Iraq. He completed internships in Iraq and the United States and performed his residency in internal medicine at Cook County Hospital, Chicago. He completed his cardiology fellowship at Sinai Samaritan Medical Center in Milwaukee.

Michael J. Kellum, MD, emergency medicine physician, has joined the medical staff of Mercy Health System, and will be providing urgent care services at the Mercy Medical Walworth Urgent Care Center. Certified by the American Board of Emergency Medicine and the American Board of Pediatrics, Dr Kellum earned his medical degree from the University of Minnesota and received additional medical training at the University of Illinois, University of Minnesota-Hennepin County Hospital and St Gorans Children's Hospital in Stockholm, Sweden.

James A. Milford, MD,* has been appointed the medical director of Rainbow Hospice Care. He is a family practitioner with the Lakewood Family Clinic in Lake Mills. His experience includes family practice at St Michael's Hospital in Milwaukee, Lakeland Hospital in Elkhorn and Watertown Memorial Hospital. Howard S. Paul, MD, has joined the staff of Mercy Options Comprehensive Mental Health and Addiction Treatment Services as a psychotherapist and addictionist. He was formerly in private practice in Carol Stream, Ill.

Richard Steliga, MD,* a general and vascular surgeon, joined Mercy Walworth Medical Center. A graduate of Marquette University, he earned his medical degree from the University of Wisconsin School of Medicine. He served an internship and surgical residency at St Joseph's Hospital in Milwaukee before joining the US Navy in 1977. He was a surgeon on the aircraft carrier USS America and worked at the naval hospital at Great Lakes Naval Base. He was employed at St Joseph's Hospital as a surgeon for 16 years.

Peter G. Van Oosten, MD, an obstetrician and gynecologist, has joined the team of physicians at the Two Rivers Clinic. He is a native of Detroit. He received his medical degree at Michigan State University and served an internship in internal medicine at Bronson and Borges Hospitals in Kalamazoo, Mich. He completed his residency in obstetrics and gynecology at Oakwood Hospital in Dearborn, Mich. Dr Van Oosten served as a clinical instructor at Michigan State University College of Human Medicine. He most recently practiced medicine in Salisbury, NC, where he was the vice chief of obstetrics and gynecology at Rowan Memorial Hospital.❖

Obituaries

Brei, Frederick A., MD, died Dec 1, 1994. He was born April 29, 1918, and received his medical degree from Marquette University School of Medicine. He served an internship at the University of Wisconsin Hospital, and was in the US Army Medical Corps during WW II. Dr Brei was in private practice in Oshkosh where he served as chief of staff at Mercy Hospital. In 1959, he joined the Aid Association for Lutherans and later became the medical director. He retired in 1983. Dr Brei was a member of the Outagamie County Medical Society, SMS, and AMA. Survivors include his wife, Margaret, of Appleton; a son, Charles Frederick Brei, daughter-in-law, Linda, and grandson, Thomas Brei.

Brickbauer, Arthur J., MD, died Nov 22, 1994, in Plymouth. He was born April 30, 1898. He served in the US Army during WW I, prior to receiving his medical degree from the Michigan Medical School. He practiced in the Plymouth area for 60 years, retiring in 1984. The Plymouth Hospital (now known as Valley View Medical Center) dedicated the Dr Arthur J. Brickbauer Building in his honor in 1985. Dr Brickbauer was a member of the SMS, Sheboygan County Medical Society, and the AMA. Survivors include his wife, Arlone; one daughter, Jane Ewbank, West Lafayette, Ind.; one son, Charles Brickbauer, Baltimore, Md; three

grandchildren; eight great-grandchildren; one sister and one brother.

Cameron, Graham, MD, died Nov 2, 1994, in North Fort Myers, Fla. Dr Cameron graduated from the University of Chicago Rush Medical College in 1939. He served an internship and surgical residencies at Cook County Hospital and Presbyterian-St Luke's Hospital in Chicago until 1943. He served in the US Army Medical Corps during WW II in the South Pacific from 1943 to 1946. He completed surgical residencies in 1948. He was a board-certified general surgeon in Eau Claire from 1948 until his retirement in 1976, serving his last 5 years as an emergency room physician at Sacred Heart Hospital. Dr Cameron was a member of the medical staffs of Sacred Heart and Luther Hospitals, the AMA, the SMS, the Eau Claire-Dunn-Pepin County Medical Society, and the Wisconsin Surgical Society. He is survived by his wife, Lou; daughters, Kathryn Norderhaug, Madison, Patricia McGhee, Gainesville, Fla, Cynthia Brown, Santa Clara, Calif, Margaret Higley, Eau Claire; a brother, and seven grandchildren.

Gallagher, Frank J., MD, died Nov 16, 1994, in La Crosse. Dr Gallagher was born April 30, 1911. He graduated from St Louis University Medical School and began his practice in La Crosse in 1938. He joined the US Army and served as a captain in the Medical Corps during WW II. He was a fellow in the American College of Surgeons, and a member of the SMS and the La Crosse County Medical Society. Dr Gallagher is survived by his wife, Ruth; and his children, James P. Gallagher, La Crosse, Mary Ellen Gallagher, Denver, Colo, Michael F. Gallagher, Breckenridge, Colo; Daniel E. Gallagher, Big Flats, NY; Joseph W. Gallagher, Los Angeles; and four grandchildren.

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.❖

Garner, Lawrence L., MD, FACS, died Oct 8, 1994, in La Jolla, Calif. He was born February 23, 1908. He received his medical degree from the University of Wisconsin in 1932, and served an internship at Mt Sinai Hospital in Milwaukee. He served his residency at the University of Illinois Eye and Ear Infirmary. Dr Garner was the director of the glaucoma clinic at Milwaukee County Hospital from 1951-1966. He was a member of the MilwaukeeCounty Medical Society, SMS, AMA, American Academy of Ophthalmology, fellow of the American College of Surgeons, member of the National Society for the Prevention of Blindness, Milwaukee Ophthalmic Society, and a diplomate of the American Board of Ophthalmology. He is survived by his wife, Lillian.

Johnson, David B., MD, died Oct 5, 1994. He was born May 14, 1928. He served with the US Army from 1951 to 1953, and graduated from Marquette Medical School in Milwaukee in 1958. He served his internship at St Mary's Hospital in Duluth and practiced medicine in Mondovi until 1984. He was an honorary life member of the Tri-County Medical Society and a member of the SMS. He is survived by a son, Ben Johnson of Princeton; and a daughter, Juliet Johnson of Madison.

Jurgens, George H., MD, died Dec 4, 1994, in Wauwatosa. He was born Aug 19, 1904. He graduated from the State University of Iowa Medical School and interned at Lutheran Memorial Hospital, Chicago, and the Cleveland, Ohio, Municipal Sanitorium and Muirdale Sanatorium, Wauwatosa. Dr Jurgens was a pulmonary physician at the former Muirdale Sanitarium in Wauwatosa from the late 1930s until 1970. He was a professor emeritus at the Medical College of Wisconsin. He was a member of the Milwaukee County Medical Society and the SMS. Survivors include his son, Phillip, and three granddaughters.

McDermott, James F., MD, died Oct 17, 1994, in Waupaca. He graduated from Creighton University Medical School in Omaha, Neb. He served his internship at Providence Hospital in Seattle. He was a battalion surgeon in the 35th Infantry in WW II. He was wounded at the Battle of the Bulge, and received a purple heart and bronze star. He served a general residency at Mac Neal Memorial Hospital in Berwyn, Ill. He was in general practice in Pulaski and Green Bay from 1947 to 1957. He served a residency at the Veterans Administration Hospital in Wood, and later served as chief of the department of physical medicine and rehabilitation. Dr McDer-

Continued on next page

mott was a past president of the Wisconsin Society of Physical Medicine and past chair of the department of physical medicine at St Joseph Hospital in Milwaukee. He was a member of the Milwaukee County Medical Society and the SMS. Dr McDermott is survived by his wife, Peggy; two sons, James and John, both of Milwaukee; three daughters, Margaret and Mary McDermott, of Wauwatosa, and Patricia Binius of Waukesha; two grandchildren; and a sister.

Mufson, Joseph A., MD, died Nov 24, 1994, in Milwaukee. He attended the University of Wisconsin and Johns Hopkins University School of Medicine, specializing in neurological surgery. He served an internship at Wisconsin General Hospital and his residency at Bellevue Hospital, Montefiore Hospital and Jewish Hospital of Brooklyn, all in New York City. He was Associate Clinical Professor of Neurosurgery at the Medical College of Wisconsin and was a member of the American Association of Neurological Surgeons, Congress of Neurological Surgeons, Central Neurological Society, Milwaukee Academy of Medicine, the SMS and the Medical Society of Milwaukee County. He is survived by his wife, Anne; and one daughter, Elizabeth Lewis, of Bayside; one brother, and three grandchildren.

Schultz, Donald W., MD, died Nov 27, 1994, in Marshfield. He was born Oct 18, 1930. He received his medical degree from the University ofWisconsin Medical School in 1956. After completing his internship and residency training in the US Army Medical Corp, he practiced medicine and surgery in Shawano for thirty years. Dr Schultz was a member of the Shawano County Medical Society and the SMS. He is survived by his wife, Virginia; four children, Rev Mark, of Eau Claire, Robin LeMoine, of Marshfield, Kevin, of Apple Valley, Minn., Scott, of Parker, Colo; 11 grandchildren; three brothers and three sisters.

Shore, Richard T., MD, died Dec 24, 1994, in Franklin. Dr Shore received his medical degree from Marquette University in Milwaukee. He served his internship at St Joseph Hospital, Denver, Colo and a residency at Milwaukee County General Hospital. He was the chief of cardiac and thoracic surgery at St Luke's Medical Center in Milwaukee. Dr Shore was a member of the Medical Society of Milwaukee County and the SMS. He is survived by two sons, James, of Albuquerque, NM, and Christopher, of Elm Grove; two sisters and three brothers.

Smejkal, Walter F., MD, died Dec 5, 1994, in Manitowoc. He was a surgeon and chief of staff at Holy Family Hospital for many years in the 1970s. He received his medical degree from the University of Illinois, and served his residency at Hines Veterans Hospital in Maywood, Ill. He was a member of the 50 Year Club of the SMS, and was honored in 1981 by the Manitowoc County Medical Society for more than 30 years of community service. He was also a member of the AMA, the Wisconsin College of Surgeons, and the Wisconsin Surgical Society. Dr Smejkal is survived by his wife, Harriett, a son, daughter, and three grandchildren.

Wallace, Charles C., MD, died Oct 23, 1994, in Appleton. He received his medical degree from Georgetown University, in Washington, DC, and completed his residency training at the University of Wisconsin-Madison. A family practitioner, he joined the Medical Arts Clinic in Appleton in 1977. He was one of the prime movers in the 1989 merger of Medical Arts Clinic and Nicolet clinic, which was then renamed La Salle. He was elected the first chairman of the board of the new corporation and continued in that role until 1993. In 1991, after a 15-year practice in family medicine, he was elected president of La Salle. He was also instrumental in the formation of the integrated delivery networks, Network Health System, Inc. He served as president of the Society of Physicians in Administration and was active in the Medical Group Management Association, the American College of Physician Executives, the Group Practice Improvement Network and the United Medical Group Association. Dr Wallace is survived by his wife, Joan, and six children, Matthew, Mary, Catherine, Joseph, Veronica, and Teresa.◆

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All manuscripts will be edited by the *Journal* staff for clarity, organization, grammar, spelling, and punctuation, and in accordance with AMA style (AMA *Manual of Style*, 8th ed, and AMA *Manual for Authors and Editors*). Suggestions for titles are welcome, but are subject to the constraints of clarity, space, grammar and style.

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Methods--Describe the selection of observational or experimental subjects, including controls. Identify the methods, procedures and equipment well enough to allow replication.

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References--Limit to 20. Authors are responsible for the accuracy and completeness of references. References must follow AMA style and abbreviations of journal names must follow those in *Index Medicus*. Consult the *Wisconsin Medical Journal* for examples of proper form.

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- Do not use abbreviations in the title or abstract, and limit their use in the text. Acceptable abbreviations of clinical, technical and general terms can be found in the AMA *Manual for Authors and Editors* and AMA *Manual of Style*.
- Avoid the use of medical jargon. Words or phrases that are particular to conversations among medical personnel are inappropriate in scientific writing. (Examples: For "presented with" use "had;" for "experienced a weight loss" use "lost weight.")
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toral degrees (eg, MD and PhD, or MD and DDS), either or both may be used, according to the author's preference. Honorary American designations (eg FACP or FACS) are omitted. If the author holds a doctorate, master's and bachelor's degrees are omitted. Courtesy titles (eg, Mr, Mrs, Ms) are omitted from bylines and text.

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Continued

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Miscellaneous

Medical Meetings - Continuing Medical Education

4TH ANNUAL NEUROLOGY FOR PRIMARY CARE PHYSICIANS. Friday, May 19 - Saturday, May 20, 1995. Landmark Resort and Conference Center, Egg Harbor, Wisconsin (Door County). Contact: Marshfield Clinic, Office of Medical Education, 1000 North Oak Avenue, Marshfield, WI 54449. 1-800-541-2895.

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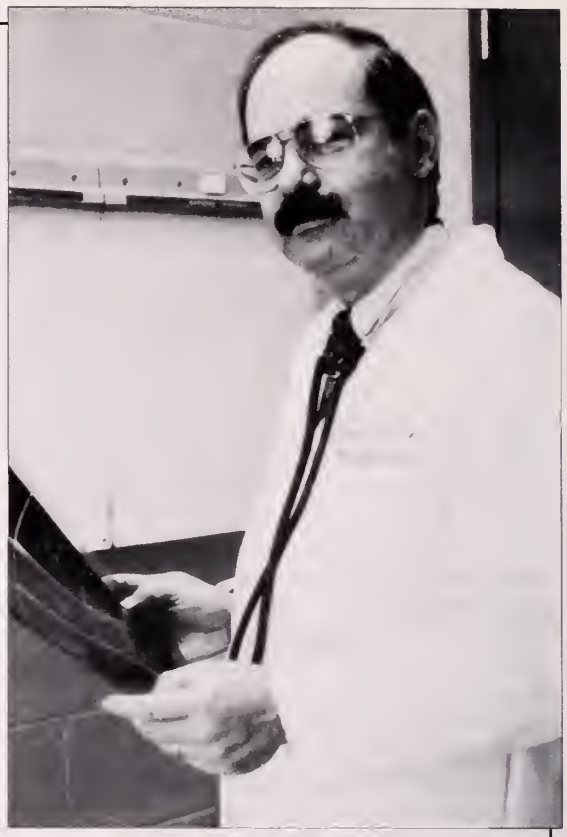

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The costs of brain and spinal injuries

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Created by the Territorial Legislature in 1841 and now representing nearly 8,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal*.

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President's page
A defining moment

I AM OFTEN STRUCK BY how the outcome for many patients seems to turn on a defining moment--that brief period during which the patient moves from an uncertain state of possible disaster to one of certain recovery or death. The recent elections may represent such a defining moment for the United States and American medicine.

Contract with America

The Republican "Contract with America" offers physicians the possibility of relief from burdensome legalisms that may be of questionable value for patients: CLIA, OSHA, and the unpredictable terror of medical malpractice litigation. There is a better than even chance that some of these burdens will be eased soon; as of this writing, only minor differences between the tort reform passed by the Senate and the Assembly stand between Wisconsin and meaningful medical malpractice reform. In our anticipation of better times to come--at least when it comes to administrative aggravations--we must be mindful of the overall health of American medicine.

The contract's fine print

Enthusiasm for privatization and market-based reforms should be tempered by the harms that will likely accompany them.

For instance, all welfare reforms are not created equal. The WIC program saves, by various accounts, $4 to $8 in future health and welfare costs for every $1 "invested" in the early nutritional lives of children born to less advantaged families. Regardless of the exact return on the investment, cuts to WIC funding will have health implications for our patients.

Richard G. Roberts, MD, JD

Some threats to our patients' health are less direct and less obvious. The average blood-lead levels of American children has reportedly dropped by 75% since the federal government began phasing out leaded gasoline. Most observers agree, however, that had the "Contract with America" been in force 20 years ago, the ban on leaded gas could never have taken effect.

The "Contract" could also have

Continued on next page

Continued from preceding page
social implications that affect our patients and our practices. The eternal human need to amass power and wealth have resulted in abuses. The major reason for the Wisconsin progressive movement at the turn of the century was the oligopolistic practices of a few timber barons and oil magnets. A variety of populist reforms followed those excesses, such as worker's compensation laws, unemployment tax, and, following the Great Depression, social security and a host of other social welfare programs.

If the eventual effect of the Contract with America is to concentrate wealth and power in the hands of a few to the detriment of the many, we can expect social unrest and a swinging of the pendulum back toward a more utilitarian model. What does all this mean for medicine?

The profession's contract

Our defining characteristic as professionals has been, and should be, placing the needs of our patients above our own as we serve them in the professional setting. Changing market forces threaten our ability to maintain that focus. Increasingly, we are viewed as economic means to some distant corporate ends. We watch the increasing consolidation of power into fewer hands that are several times removed from the patients they claim to serve. The risk is that health care will become dominated by these remote, financially driven, capital-intense monoliths. This would be in keeping with consolidations in other large industries in the United States (eg, automobile manufacturing), but there remains something fundamentally different about health care and other service industries. Much of the healing experience hinges on relationships and the special trust that occurs.

The end of medicine

I do not mean to suggest that any one system of care is necessarily better or worse than another: excesses have occurred in the traditional fee-for-service solo practice as well as in socialized single-payer systems. Rather, my concern is that the changes under way challenge the profession to respond to the fundamental human need for caring. I worry that the profession, as well as America, may find itself unraveling into a Tower of Babel: medical enterprises and specialties divided and fighting over turf. Without constant commitment to our common professional interest--the needs of the patient--we run the risk of becoming irrelevant. Others can be hired less expensively to accomplish a number of the various tasks of health care services, although no one brings them all together with the same effectiveness as a physician.

We must strive constantly to do better in our individual patient care; we must remain vigilant in our efforts to improve the health of all in our communities. It is understandable that uncertain times can tempt us to limit ourselves to the comfort and security we try to achieve in our offices, hospitals, and homes. Our dedication to our professional contract and our ability to understand the possibilities and the perils of the "Contract with America" will determine how we are seen to respond to this defining moment.❖

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EVP report: The view from here
No time for laurel resting

SOMETIMES, it takes a long time for the right thing to happen. But with the right combination of perseverance, hard work, circumstances and good luck, good sense eventually overcomes nonsense. So it is with our efforts to cap non-economic damages in medical professional liability cases. Tort reform measures long-sought (emphasis on "long") by the SMS are closer to becoming reality as the State Senate recently approved the medical liability reforms contained in Assembly Bill 36, which seeks a $350,000 cap on non-economic damages, application of the $150,000 cap on wrongful death awards to medical malpractice cases, and payments of future medical expenses exceeding $100,000 on an as-incurred basis.

The bill has been returned to the Assembly for its approval of technical language attached to the bill by the Senate Judiciary Committee, as well as an amendment passed by the full Senate that modifies the collateral source rule. Under the amendment, evidence of other awards received by the plaintiff may be offered as evidence in a medical malpractice trial. At this writing, the Assembly is expected to take up the bill during its next floor period, scheduled for April 4-6.

Let me tip my metaphorical hat, once again, to the dedicated physician volunteers and the SMS government relations staff on this achievement. If we win final approval, and if the governor honors his promise to sign the bill into law, the effects will be immediate. Already, the Patients Compensation Fund Board of Governors has indicated that it will recommend an across-the-board 11.2% decrease in PCF premiums for fiscal year 1995-1996. Without the cap, PCF premiums are slated to increase by 4%. (Please see the accompanying box for a list of senators who supported AB 36. If your senator is listed, drop him or her a note and say "thanks.")

Two essential battles have now been won, but the war is not over. And even if our entire tort reform package became law tomorrow, your involvement would remain crucial. First, because every new election will bring new efforts by our political opponents to undo the good that is--we hope--about to be done. Constant vigilance, as the axiom goes, is the price of liberty (or, in this case, the price of common sense). Second, your involvement is still needed because the SMS is about a lot more than tort reform. There are a good many issues that promise consequences for you, your practice, and your patients.

In the next few months alone, the Wisconsin Legislature will consider--in addition to tort reform--proposals on physician licensing fees, Medicaid funding, WIC funding, trigger locks, physician-assisted suicide, concealed weapons, "right to die" issues, general assistance funding, organ donations and local public health initiatives, to name a few. These and other issues can have effects on the well-being of the very people you are dedicated to keeping healthy.

Thomas L. Adams, CAE

Stay tuned. Stay in touch. Stay involved. The work of your medical society continues. ❖

Tort reform supporters

The following state senators voted in favor of AB 36: Joe Andrea (D-Kenosha); Carol Buettner (R-Oshkosh); Robert Cowles (R-Green Bay); Alberta Darling (R-River Hills); Gary Drzewiecki (R-Pulaski); Michael Ellis (R-Neenah); Margaret Farrow (R-Elm Grove); Scott Fitzgerald (R-Juneau); Joanne Huelsman (R-Waukesha); Alan Lasee (R-DePere); Joseph Leean (R-Waupaca); Mary Panzer (R-West Bend); George Petak (R-Racine); Peggy Rosenzweig (R-Wauwatosa); Brian Rude (R-Coon Valley); Dale Schultz (R-Hillpoint); Tim Weeden (R-Beloit); and David Zien (R- Eau Claire).❖

Letters

Arrogant editors

An editorial entitled "Arrogant faculty" in the January 1995 *WMJ* suggested several reasons for the resignation of UW Medical School Dean Larry Marton. The theories included a conspiracy of greedy subspecialists intent on mortally wounding the fledgling primary care initiatives of the medical school and a cabal of "foreign nationals" with a callous disregard for the "desperate need of the people of Wisconsin--and for that matter, the citizens of this country--for more primary care physicians." The author's speculations piqued reader interest and inflamed heated discussions--I have received nearly three dozen angry comments on the editorial.

I have several concerns with the editorial. In aspiring to sensational journalism, the medical editor got it wrong and caused a fair bit of hurt along the way. I have been as intimately involved with the primary care transformation of the UW Medical School as anyone. I have practiced as a family physician in rural Wisconsin communities of fewer than 2,500 for the past 12 years, I joined the university in 1987 for the purpose of helping in its transformation, I served as chair of the Department of Family Medicine in 1992-1993, and I have been an active participant in the deliberations to form a UW group practice. I suspect the editor did not know what he did not know.

Dr Marton's commitment to primary care, which I applauded, was not the reason for his departure. Rather, the decision to have him step down was made by Chancellor David Ward because of differences in leadership and administrative styles. That decision was for the chancellor alone to make; apparently it was not a good fit. I remain an admirer of Larry Marton: He is an energetic, eloquent, and forthright person who encouraged medical school faculty to reach out to other physicians in Wisconsin and to the State Medical Society.

My other concern is the possible perception that the views of the author's might be taken as the views of the SMS. Conspiracy theories and xenophobia have not been, nor will they be, tolerated as policies of the SMS. The strength and vitality of America are the dynamic and creative mix of people, personalities, and perspectives we call the United States. We are *all* immigrants to this great land, beginning with those who braved the walk across the Bering Straits.

The literary tension that challenges every journal is the desire to present objective information and medical society policies with the desire to allow individuals to speak their piece without censure. The SMS and the *WMJ* have a noble tradition of balancing those desires effectively. Readers are reminded in a boxed inset in every issue that editorials are signed by the author and reflect the opinions of the author, not necessarily the policies of the Society.

The editorial in question reflected one person's views, not a position of the Medical Society. At best, it was misinformed; at worst, it was mean spirited. The editorial did serve two useful purposes. It provoked many physicians (university, international medical graduate, and other physicians) to speak up and demonstrate that we have much more in common that unites us than we have differences that separate us. It also served as a recent reminder of age-old advice: Don't believe everything you read.

--Richard G. Roberts, MD, JD
SMS president ❖

UW Medical School faculty are dedicated to patients' needs

To the editor: We believe that the recent editorial by medical editor Richard D. Sautter, MD, which impugns the motives and goals of the University of Wisconsin Medical School faculty deserves a reply. In our view, neither dissatisfaction with the articulated goal of increasing the number of graduates who go into primary care nor changes in faculty practice plan, which would alter the style of practice and monetary remuneration, were substantial factors in Dean Laurence Marton's resignation.

We believe that the Medical School faculty and the administration, including Philip Farrell, the dean ad interim, and former Dean Marton are well aware of the need to increase the number of graduates interested in primary care and have set policies in place to do this. While all faculty do not necessarily agree with this posture, it is widely recog-

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nized that this trend in American medicine must be acknowledged and positively addressed. That this is so is attested to by the fact that the chair of the committee to select the new dean is the chair of family practice.

Faculty monetary compensation is largely generated through the private practice of medicine. When the school was founded more than 60 years ago, private practice was carried out on a small scale in the usual and customary manner. That was, individual physicians billing their individual private patients. Gradually, as the role of University Hospitals changed, and the faculty expanded, a private practice plan with more structured remuneration evolved. In the 1970s, that plan was modified into a more comprehensive operation to enhance the practice of medicine, which was the source of patients for teaching. This plan was structured so that there was an up-front "Dean's Tax" on income derived from practice. This has resulted in tens of millions of dollars of funds available to the dean's office to enhance the goals for the Medical School. This plan, which had incrementally evolved, has served the school well.

In the 1990s, medicine is not undergoing evolutionary, but rather cataclysmic, changes. The style of practice has altered with the onset of governmental programs, managed care, and the realignment of providers. The faculty has recognized the need to respond in a meaningful and purposeful way, and is in the process of restructuring our practice. Some members of the faulty have reacted, just as some of the general public does (ie, they abhor the idea). Others feel that their incomes may be reduced and are opposed because of monetary self-interest. It is our belief that these groups represent a minority of faculty members. It is our view that the vast majority of the faculty recognized the need for change and alterations in the patterns and possibly amount of remuneration. We believe Dr Sautter's extrapolation from an interaction with a small number of people at a long range planning session is unjustified.

Dr Sautter manifests xenophobia in raising the specters of foreign nationals organizing a cabal to thwart the above described changes by unseating the dean.

It is our belief that the majority of the faculty at the UW Medical School are dedicated to serving the needs of the public and our patients and our students. We recognize that change in education, style of practice, and remuneration may be necessary to carry out the mission of the Medical School and are attempting to implement them.

--Andrew B. Crummy, MD
Madison
--Joseph F. Sackett, MD
Madison❖

More on the dean

To the Editor: The editorial presented by Richard D. Sautter, MD, in January 1995 *WMJ* expressed valid outrage over the resignation of Dean Laurence Marton.

I take issue, however, with his statement that foreign nationals consider medical needs of US citizens a low priority. Dr Sautter fails to recognize that most doctors who were trained abroad now consider America their permanent home, and American interests are their own interests. Ironically, the percentage of international medical graduates providing primary care in the inner cities speaks for their dedication.

--Ayaz M. Samadani, MD
Beaver Dam❖

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

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Letters are signed by the authors. These opinions are the authors' and do not necessarily reflect the policies of the SMS. Authorship of letters is open to the public, but letters are limited to 500 words and subject to review by the *WMJ* editorial board. Write to: *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701.❖

A better way to reduce AFDC costs

To the Editor: The primary target of welfare reform is Aid to the Families of Dependent Children. The purpose of AFDC is to help children by temporarily supporting parenting. It does just that in most instances.

Fifty-four percent of AFDC recipients receive benefits for less than 2 years and 75% for less than 4 years. These facts are easily overlooked because 65% at any one time are long-term recipients. Many of them are unemployable. At least one in four neglect and abuse their children.

To counteract welfare dependency, the emphasis of AFDC has shifted from parenting children to obtaining jobs for parents. But the existence of a child is the wrong trigger for job training and finding. Efforts to employ vulnerable parents often defeat the purpose of AFDC by adding to their stress and increasing child neglect and abuse.

The employment of all AFDC parents would not save money when all costs are taken into account. The earnings of a parent usually do not defray the costs of living and quality day care. Employment and training services can double the costs, and available jobs are unlikely to move parents out of poverty. Continuing the emphasis on providing employment for all AFDC parents will lead to expenditures on people who would have left welfare in a short time anyway, and will not achieve financial independence for most long-term recipients.

The way to cut welfare costs and to reduce the child neglect and abuse that leads to habitual crime and welfare dependency is to prevent people who are likely to become welfare dependent from entering the AFDC rolls. This can be done by identifying incompetent parenting and repairing the flaw in AFDC that permits half of the parents who neglect and abuse their children to receive public assistance without interventions until their children are damaged.

More than half of the AFDC benefits are to mothers who bore their first children as adolescents. If the formation of new teenage families could be prevented, welfare dependency would be sharply reduced. Holding males and parents of minors responsible for child support and promoting realistic attitudes toward teenage pregnancy discourages teenage childbirths. Removing the incentives for keeping children rather than placing them for adoption furthers the developmental interests of both adolescent parents and their children.

The entry of likely long-term AFDC recipients could be reduced substantially by eligibility criteria, such as: the parent is an adult or is supported by a competent parent; the parent makes a commitment to childrearing; and the parent receives parenting education and necessary treatment. Incompetent parents should receive help. If they are unable or unwilling to competently parent their children, child abuse and neglect laws should be followed with timely termination of parental rights and adoption of the children.

We should not miss this opportunity to strengthen AFDC so that it legitimately aids competent parents during crises in their lives without contributing to incompetent parenting and thereby aggravating the violence and crime that currently drive the reform movement.

—Jack C. Westman, MD
Madison ❖

On primary care

To the Editor: Our medical schools must continue to address the shortage of physicians affecting many Wisconsin communities. A recent study by the UW Medical School ("Wisconsin's future requirements for generalist physicians," *Wisconsin Medical Journal*, January 1995) questions the need to increase the supply of primary care physicians for the year 2015.

The study makes a reasonable case for questioning some of our long range planning assumptions about the total number of physicians that we should be training. But while the study notes the need to improve the distribution of physicians throughout the state it understates the critical role to be played by medical schools.

Nationally, medical schools have found innovative ways to increase the number of their graduates that choose to work in rural and inner-city communities. Wisconsin must continue to hold its two medical schools accountable for similar initiatives. At least two common interventions need to be expanded in Wisconsin—recruiting qualified students from rural and inner-city communities and getting selected medical training off-campus into under-served communities.

—Tim Size, executive director
Rural Wisconsin Hospital Cooperative
Sauk City❖

Do seatbelts save lives?

To the Editor: My physician wife recently brought home the January 1995 issue of *WMJ* and I happened to see McBride, et al's work entitled "Do future physicians have healthy lifestyles?" I was intrigued by the notion implicit in this study that the use of seatbelts somehow connotes a "healthy lifestyle." The more correct question would have been "How often have you crashed your car?" Let me explain.

Since seatbelt use was mandated in Wisconsin in December of 1987, somewhere between 888 and 1326 people have died in car crashes while wearing seatbelts (this does not include 1994 fatalities). In addition, between 1989 and 1993 some 14,077 people received "incapacitating injuries (the Wisconsin DOT's most severe category of injury) while wearing seatbelts. Clearly, these belted deaths and injuries are not consistent with the notion that seatbelts promote a "healthy lifestyle."

Total auto occupant deaths in Wisconsin have averaged about 500 since 1988. The high was 560 in 1989; the low was 445 in 1992. Total highway injuries have stayed almost constant at about 61,000. Death and injury rates continue to decline--as they have since the 1920s--as these relatively constant numbers are divided by ever-increasing miles traveled. The death and injury problem has not been solved, only diluted.

According to the claims of belt law proponents in 1987, by now the law should have saved 1,680 lives, prevented 210,000 injuries and reduced Wisconsin health care costs by $1.4 billion dollars. None of this has happened.

We know now that all funding for belt law proponents in Wisconsin and the rest of the country came from a single source: the auto industry. The total amount given to lobbyists and political organizers amounted to $93.2 million (about $1 million was spent in Wisconsin). The quality of the information

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distributed to lawmakers and the general public by these people was not good.

I challenge any Wisconsin physician or epidemiologist to the following exercise in futility: ask Wisconsin DOT Secretary Charles Thompson or Attorney General James Doyle to provide a list of the number of fatalities that are suspected of being secondarily related to seatbelt use. Also ask for an estimate of the number of people who have escaped death or severe injury because they were not belted at the time of their crash. I believe you will find extreme reluctance on the part of any public official to address the "downside" of seatbelt use and related concerns.

The number of belt law violation citations issued by Wisconsin police officers has risen from 13,781 in 1988 to 75,261 in 1994--a 450% increase. To date, some 310,477 people have received belt tickets. Despite this enforcement level, no belt law compliance goal has ever been met.

Incidentally, documented air bag deployments in Wisconsin have increased from 26 in 1988 to 767 in 1993, but there has not yet been any noticeable effect upon overall fatalities.

Am I arguing against seatbelt use? Of course not! But crash-free driving is so far preferable to belted crashing that it must be that goal that is impressed upon each and every patient by all Wisconsin health care providers. Courteous, careful driving is a genuine part of a "healthy lifestyle."

—Mark Halter
Stoddard❖

Soundings
Of Primary Concern

You
Don't talk
To me anymore
You can't
Numbers
Prevail and
Volume dictates
Business
Who knows
My story
My fear
My secret
My self

Time and talk
Commodities now
Social bonds
Trust and
Laughter
Acquiesce
To
Silence
And
Statistics please
Help me please
Listen...

--James E. Casanova, MD
Milwaukee❖

A word of thanks

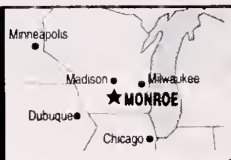
To the Editor: Having served on the Task Force for the Medical Society of Milwaukee County several years ago, which added to the Society's mission statement a phrase urging physicians to increase their participation in community affairs, it seemed to me that one should practice what they preach and so I have.

Those involved in community service, in addition to the practice of medicine, appreciate the opportunity to serve large segments of the community in the same fashion that we each serve individual patients in our practices.

My thanks to you and to the Board, and to the Society for the honor. In hopes of furthering physician participation in community affairs.

--Nicholas L. Owen, MD
Milwaukee

Editor's Note: Dr Owen is one of the 1995 winners of the SMS Physician-Citizen of the Year award.❖



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Conjoint screening questionnaires for alcohol and other drug abuse: criterion validity in a primary care practice

Richard L. Brown, MD, MPH, and Laura A. Rounds, MSSW, Madison

The US Preventive Services Task Force recommended that physicians use the CAGE questions to screen patients for alcohol abuse. A similarly brief screening instrument for abuse of other drugs is needed. Two conjoint screening questionnaires for alcohol and other drug abuse were adapted from the CAGE questions and the Short Michigan Alcoholism Screening Test (SMAST). For 124 patients of an academic, community family practice, the conjoint questionnaires and their forerunners were compared with DSM-III-R diagnoses of substance use disorders as measured by the Diagnostic Interview Schedule-Revised (DIS-R). The SMAST and its conjoint analog exhibited low sensitivity. The CAGE Adapted to Include Drugs (CAGE-AID) was more sensitive but less specific for substance abuse than the CAGE, especially when a reduced criterion score was employed. The CAGE-AID was more sensitive than the CAGE for subjects of varying sex, income, and level of education, as well as most patterns of substance use disorders. The diminished specificity of the CAGE-AID may have been, at least in part, artifactual. The CAGE-AID holds promise for identifying primary care patients with alcohol and drug disorders.
Wis Med J.1995;94(3):135-140.

Approximately 5.5 million Americans fulfill diagnostic criteria for drug abuse or dependence and are suitable candidates for drug treatment.[1] Such treatment, including methadone maintenance, therapeutic communities, and outpatient nonmethadone programs, appears to be effective for typical clients under typical conditions.[1] A substantial number of drug abusers are detected in the criminal justice system, but for the majority, the health care system offers an important opportunity for detection, initiation of treatment, immunization against hepatitis B, and prevention and early identification of human immunodeficiency virus infection.[1,2] Primary care physicians, in particular, are poised to detect and intervene in drug abuse.[3-5]

The US Preventive Services Task Force[6] recommended in 1989 that physicians use the CAGE questions[7] to screen their patients for alcohol abuse. The task force also recommended that physicians attempt to identify patients who abuse other drugs but did not recommend a specific screening instrument for drug abuse, presumably because the available questionnaires[8-11] were either too lengthy, inaccurate, or unsuitable for adults. A recent study showed that specific questions on recent cocaine use often fail to elicit accurate responses,[12] and there is widespread clinical impression that the same is true for questions on the use of other drugs. Thus a drug abuse screening instrument for health care is needed.[2]

Several problems must be overcome in developing a useful drug abuse screening instrument. The instrument must be accurate. To facilitate accurate reporting, affirmative responses to the items should not reveal information which, if recorded, could jeopardize patients' ability to obtain insurance. The questionnaire should be brief, and the scoring scheme should be easy to memorize and administer, like the CAGE questions. The items should be as innocuous as possible

Dr Brown and Rounds are with the Department of Family Medicine at the University of Wisconsin Medical School; the medical school and the department provided the funding for this project. Reprint requests to: Richard L. Brown, MD, MPH, University of Wisconsin Medical School, Department of Family Medicine, 777 S Mills St, Madison, WI 53715. Copyright 1995 by the State Medical Society of Wisconsin.

so that ensuing efforts to assess for drug problems, and patients' relationships with their health care providers, are minimally compromised. The instrument should take into account that 20% to 43% of all substance abusers abuse alcohol and at least one other drug.[8,13]

Conjoint screening questionnaires, which assess simultaneously for alcohol and drug problems, may be able to satisfy these requirements. A central feature of these conjoint questionnaires is that affirmative responses disclose alcohol or illicit drug use. This study examines two new conjoint screening questionnaires—the CAGE questions Adapted to Include Drugs (CAGE-AID) and the Short Michigan Alcoholism Screening Test Adapted to Include Drugs (SMAST-AID). The questionnaires (Table 1) were produced by modifying items of the CAGE questions[7] and the Short Michigan Alcoholism Screening Test (SMAST).[14] For example, the question "Have you ever felt bad or guilty about your drinking?" was changed to "Have you ever felt bad or guilty about your drinking or drug use?"

Previous studies suggest that the CAGE-AID and SMAST-AID can reflect simultaneous use of at least two substances (R.L. Brown, MD, and L.A. Rounds, MSSW, unpublished data, 1994). These questionnaires appear to be more sensitive than the CAGE and SMAST for patients in substance abuse treatment, especially those who abuse multiple substances. This study compared primary care patients' responses to the CAGE-AID, the SMAST-AID, the CAGE, the SMAST, and sections of the Diagnostic Interview Schedule-Revised (DIS-R)[15] on substance use disorders; the DIS-R served as a criterion measure for alcohol or drug problems. The questionnaires studied were:

- The original CAGE questions with the original criterion score of 2 (two positive responses taken to suggest an alcohol problem) - henceforth referred to as the CAGE2.
- The original CAGE questions with a reduced criterion score of 1 - the CAGE1.
- The CAGE Questions Adapted to Include Drugs, with the original criterion score of 2 - the CAGE-AID2.
- The CAGE Questions Adapted to Include Drugs, with a reduced criterion score of 1 - the CAGE-AID1.
- The original Short Michigan Alcoholism Screening Test (SMAST) with the original criterion score of 3 - the SMAST3.
- The original SMAST with a reduced criterion score of 2 - the SMAST2.
- The SMAST Adapted to Include Drugs, with the original criterion score of 3 - the SMAST-AID3.
- The SMAST Adapted to Include Drugs, with a reduced criterion score of 2 - the SMAST-AID2.

Table 1. — The substance abuse screening questionnaires studied.

The CAGE Questions and the CAGE Questions Adapted to Include Drugs CAGE-AID

1. Have you ever felt you ought to cut down on your drinking <u>or drug use</u>?
2. Have people annoyed you by critizicing your drinking <u>or drug use</u>?
3. Have you ever felt bad or guilty about your drinking <u>or drug use</u>?
4. Have you ever had a drink <u>or used drugs</u> first thing in the morning to steady your nerves or to get rid of a hangover?

The Short Michigan Alcoholism Screening Test (SMAST) and the Short Michigan Alcoholism Screening Test Adapted to Include Drugs (SMAST-AID)

1. Do you feel you are a normal drinker or drug use? (By normal, we mean you drink <u>or use drugs</u> less than or as much as most other people.)
2. Does your wife, husband, a parent, or other near relative ever worry or complain about your drinking <u>or drug use</u>?
3. Do you ever feel guilty about your drinking <u>or drug use</u>?
4. Do friends or relatives think you are a normal drinker <u>or drug user</u>?
5. Are you able to stop drinking <u>or using drugs</u> when you want to?
6. Have you ever attended a meeting of Alcholoics Anonymous, <u>Narcotics Anonymous, or Cocaine Anonymous</u>?
7. Has your drinking <u>or drug use</u> ever created problems between you and your wife, husband, parent, or other near relative?
8. Have you ever gotten into trouble at work because of your drinking <u>or use of drugs</u>.
9. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking <u>or using drugs</u>?
10. Have you ever gone to anyone for help about your drinking <u>or drug use</u>?
11. Have you ever been in a hospital because of drinking <u>or using drugs</u>?
12. Have you ever been arrested for drunken driving, driving while intoxicated, or driving under the influence of alcoholic beverages <u>or drugs</u>?
13. Have you ever been arrested, or taken into custody, even for a few hours, because of other behavior while under the influence of alcohol <u>or drugs</u>?

The normal text shows the original questionnaires. The adaptations for the CAGE-AID and SMAST-AID are shown by the underlined text. For the SMAST and SMAST-AID, item 1 is purely introductory and is not scored; items 4 and 5 are scored inversely, that is, a no response connotes risk.

Methods

Between July 1991 and February 1992, 124 patients of an academic, community-based family medicine clinic in Madison, Wis, agreed to participate in a study about health-related lifestyles. Eligible patients were those of age 21 or greater who were facile with spoken English, had sufficient mental status, and were not pregnant. All patients were offered $10 and informed that their responses would not be divulged to anyone, including all clinic health care providers and staff. The protocol was approved by the Human Subjects Committee of the University of Wisconsin Center for Health Sciences.

The subjects initially responded to general questions on aspects of their lifestyle, including diet, exercise, smoking, and drinking. Then they indicated whether they believed they have a problem relating to diet, exercise, smoking, alcohol, or other drugs, and they provided demographic information. Next, in a sequence that was varied systemically among subjects, they responded in writing to the CAGE, CAGE-AID, SMAST, and SMAST-AID. The subjects were instructed that the word "drugs" in the CAGE-AID and SMAST-AID referred to street drugs and addictive medications that were taken beyond how they were prescribed. Finally, the subjects responded by interview to the alcohol and substance abuse and dependence sections of the DIS-R, which assesses subjects for DSM-III-R psychiatric diagnoses.[15]

Two or more positive responses to the CAGE,[7] and three or more positive responses to the SMAST[14] are commonly interpreted to suggest alcohol abuse. Since the accuracy of screening questionnaires for a primary care population may be improved by using smaller criterion scores than those which are optimal for treatment populations,[16,17] the sensitivity and specificity for the questionnaires were assessed for the standard criterion score (CAGE2, CAGE-AID2, SMAST3, and SMAST-AID3) and for the standard criterion score minus one (CAGE1, CAGE-AID1, SMAST2, SMAST-AID2).

Table 2.—Substance-related diagnoses found in the study population

Substance	*Number of subjects with DIS-R diagnoses** Abuse	Dependence	Total
Alcohol	28	28	56
Marijuana	0	21	21
Cocaine	1	12	13
Sedatives	0	6	6
Psychedelic and Hallucinogens	1	3	4
Heroin	0	2	2
Other opiates	0	2	2
Phencyclidine	0	1	1
Total	**30**	**75**	**105**

* Of 124 subjects, 61 had no substance-related diagnoses, 38 had one diagnosis, 14 had two diagnoses, and 11 had three or more diagnoses.

Results

The subjects' mean age was 38.6 years with a standard deviation of 8.8 years. The subjects reflected the clinic's location in a mixed community: 78% of subjects were employed; 6% had not finished high school; 48% had an associate's or more advanced degree; 23% had an income at or less than the poverty level; and 62% had an income exceeding twice the poverty level.

Slightly over half (63) of all subjects fulfilled DSM-III-R criteria for lifetime abuse or dependence on one or more substances. These 63 subjects had a total of 105 substance-related diagnoses. Diagnoses of abuse of and dependence on one particular substance are mutually exclusive, but individuals may have a diagnosis of abuse or dependence for each class of substances they have used. The subjects' diagnoses are shown in Table 2.

Twenty-three subjects (19%) had diagnoses of abuse or dependence on alcohol and at least one other drug; 7 (6%) abused or were dependent on one or more other drugs but had no alcohol-related diagnoses; and 33 (27%) had only alcohol-related diagnoses. Of the latter 33 subjects, 21 (64%) qualified for a diagnosis of alcohol abuse solely by repeated use in physically hazardous situations.

Forty-four (36%) responded positively to the CAGE2 (the CAGE questions with two or more affirmative responses taken to indicate a problem); 53 (43%) to the CAGE-AID2; 26 (21%) to the SMAST3; and 29 (23%) to the SMAST-AID3. Fifty-four (44%) of the sample responded positively to the CAGE1; 64 (52%) to the CAGE-AID1; 35 (28%) to the SMAST2; and 35 (28%) to the SMAST-AID2.

Table 3 shows comparisons between the screening questionnaire results and self-reported DIS-R diagnoses of alcohol or drug abuse or dependence. The SMAST and SMAST-AID at both criterion values exhibited sensitivities of .51 or less at both criterion values and were not considered further. The sensitivities of the CAGE and CAGE-AID at both criterion values were at least 22 percentage points higher than the respective sensitivities of the SMAST and SMAST-AID. Reducing the criterion score of the CAGE and adapt-

Table 3.— Sensitivity and specificity of the CAGE, CAGE-AID, SMAST, and SMAST-AID as compared to DIS-R diagnoses

	*Using the standard criterion score**		*Using a reduced criterion score***	
Questionnaire	**Sensitivity**	**Specificity**	**Sensitivity**	**Specificity**
CAGE	.64	.93	.71	.84
CAGE-AID	.70	.85	.79	.77
SMAST	.38	.97	.49	.93
SMAST-AID	.40	.95	.51	.92

* Two or more affirmative responses were defined as a positive result on the CAGE or CAGE-AID. Three or more affirmative responses were defined as a positive result on the SMAST or SMAST-AID.
** One or more affirmative responses were defined as a positive result on the CAGE or CAGE-AID. Two or more affirmative responses were defined as a positive result on the SMAST or SMAST-AID.

ing the CAGE questions to include drugs each resulted in an improvement in sensitivity and a decrement in specificity of 6 to 9 percentage points. The effects of these modifications were additive, such that the CAGE-AID1 was 15 percentage points more sensitive than the CAGE2, and 16 points less specific.

Further analysis, shown in Table 4, revealed that the CAGE-AID1 was more sensitive to substance abuse or dependence than both the CAGE2 and the CAGE1 for 11 of 14 subgroups categorized by patterns of substance-related diagnoses, and equally sensitive for the remaining three subgroups. The gain in sensitivity from the CAGE-AID1, compared to the CAGE1, was particularly advantageous for subjects who abused or were dependent on drugs other than alcohol, and for subjects who abused or were dependent on two substances.

At standard and reduced criterion values, the CAGE-AID was more sensitive than the CAGE for women and men, but, overall, all questionnaires were less sensitive for women than men. The differences in sensitivity were not accounted for by differences in substance-related diagnoses between the sexes, since 19 of 32 men and 19 of 31 women were dependent on at least one substance, and 13 men and 12 women had abuse but not dependence. Furthermore, 19 men and 14 women had only alcohol-related diagnoses, and 12 of these 19 men and 9 of the 14 women exhibited only hazardous alcohol use, while 13 men and 17 women had drug-related diagnoses.

All questionnaires exhibited slightly greater sensitivity for subjects with less education and lower income. At both cutpoints, the CAGE-AID was more sensitive than the CAGE for individuals in all four education and income subgroups.

Discussion

This paper reports the first investigation of conjoint screening questionnaires in a primary care patient population. The results showed that the CAGE-AID, with a criterion score of 1, may be superior to the previously recommended CAGE in its sensitivity to a broader scope of substance use disorders.

The CAGE and the CAGE-AID exhibited greater sensitivity than the SMAST and SMAST-AID. Adapting the CAGE to include drugs, regardless of the criterion score used, resulted in moderate gains in sensitivity and moderate losses in specificity. Reducing the criterion score of the CAGE and CAGE-AID resulted in similar gains and losses. For most subgroups of subjects with alcohol or drug disorders, the CAGE-AID was more sensitive than the CAGE, and the CAGE-AID with a criterion score of 1 was most sensitive.

One anticipated drawback to conjoint questionnaires was diminished sensitivity for alcohol abusers who do not use illicit drugs and would not wish to be mistaken as drug abusers. Evidence for this drawback was not found, as the CAGE-AID and the CAGE were approximately equally sensitive for individuals who are abusers of or dependent on only alcohol.

This study's results highlighted the heterogeneity of substance abusers and the need for screening instruments that can screen a heterogeneous, primary care patient population. An interesting incidental finding was that all of the derivatives of the CAGE exhibited diminished sensitivity for individuals with the earliest, least severe alcohol disorders. Although many of these individuals may cause little harm to themselves and others, collectively they comprise the largest number of abusers and cause significant harm.[18] They are at risk for more severe abuse and dependence.[18] Yet these may be the individuals who may not require formal treatment and are most responsive to brief, highly cost-effective interventions.[18] The screening questionnaires were also less sensitive for women than men. Efforts to develop novel screening approaches for early abusers and women may be needed.

Although high sensitivity is often cited as the most important attribute of a screening test, a reasonably high specificity is important, as well,

Table 4.— Sensitivity of the CAGE and CAGE-AID in subgroups of substance abusers

	N	CAGE2	CAGE1	CAGE-AID2	CAGE-AID1	Difference: CAGE-AID1 v CAGE-1
Not dependent; abuses at least one substance	38	.44	.56	.52	.60	+.04
Dependent on at least one substance	25	.76	.82	.82	.92	+.10
Abuses or dependent on alcohol only	33	.55	.64	.58	.67	+.03
Hazardous use of alcohol only	21	.33	.48	.43	.52	+.04
Harmful use and dependence	12	.92	.92	.83	.92	.00
Abuses or dependent on other drugs only	7	.57	.57	.71	.86	+.29
Abuses or dependent on alcohol and other drugs	23	.78	.87	.87	.96	+.09
Abuses alcohol, with or without other drug problems	28	.64	.72	.70	.79+	.07
Alcohol abuse consists of hazardous use only	23	.43	.54	.50	.61	+.07
Alcohol abuse includes harmful use	5	1.00	1.00	1.00	1.00	.00
Dependent on alcohol, with or without other drug problems	28	.86	.93	.89	.96	+.03
Abuses or dependent on one substance	38	.55	.63	.61	.71	+.08
Abuses or dependent on two substances	14	.64	.78	.78	.93	+.15
Abuses or dependent on three or more substances	11	.91	.91	.91	.91	.00
Women	31	.52	.61	.65	.72	+.11
Men	32	.75	.81	.75	.88	+.07
Educated beyond high school	32	.56	.69	.66	.78	+.09
Educated through high school or less	31	.71	.74	.74	.80	+.06
Income > 200% of poverty level	23	.60	.65	.65	.74	+.09
Income 200% of poverty level	40	.65	.75	.73	.83	+.08

especially when false-positive results can lead to mislabeling, when denial may be a symptom of the condition, and when patients may not accept referrals for diagnostic assessments. In this study, the specificity of the CAGE-AID1 was found to be .77. For the sample studied, which had a lifetime prevalence of alcohol or other drug abuse or dependence of .51, the positive and negative predictive values were .78. In other words, 78% of subjects with one or more affirmative responses to CAGE-AID items had a DIS-IIIR substance-related diagnosis, and 78% of subjects with no affirmative responses had no DIS-IIIR substance-related diagnosis. In patient populations with a 20% lifetime prevalence of a DIS-IIIR substance-related diagnosis, with the same proportion of alcohol, drug, and combined disorders as in this population, the positive and negative predictive values of the CAGE-AID1 would be .47 and .94, respectively. Thus, as many as 53% of individuals who would have a positive result on the questionnaire would actually have no substance-related problem; for the CAGE-AID2, this proportion would be 46%. A substance abuse screening instrument would preferably have a lower false-positive rate.

Some of the false-positive CAGE-AID results may derive from a strong stigma against illicit drug use. Stronger social pressure and prevention campaigns against illicit drug use may provoke conscious decisions to cut down before drug use causes adverse effects. Family and friends may be more likely to criticize illicit drug use that has not induced negative consequences than similarly problem-free alcohol use. Individuals may feel more guilty about illicit but otherwise problem-free drug use than problem-free alcohol use. Another possible ex-

planation for false-positive CAGE-AID results may be a misunderstanding of the term "drug" as used in the questionnaire.

The criterion measure used in this study may also have contributed to the apparent lack of specificity of the CAGE-AID. The original DIS, based on DSM-III criteria, identified alcohol abuse or dependence in a community sample with .70 to .74 sensitivity and .93 to .96 specificity compared to expert clinicians using two different methods; sensitivity to drug abuse or dependence was .52 to .66, and specificity was .92 to .94.[15]

The limitations in the sensitivity of the DIS-R to drug abuse or dependence may reflect the lack of sensitivity of detailed questions about drug use in at least some primary care patients.[12] It is therefore possible that at least some subjects who appeared to have false-positive screening results may actually have had false-negative results on the DIS-R, and that the specificity determinations in this study were spuriously low. Subsequent studies could use collateral reports and urine drug screens to enhance and ensure the validity of a self-report criterion measure.

The study's generalizability may be limited in that it focused on patients at only one clinic. This clinic population appeared to reflect Wisconsin's high prevalence of hazardous drinking[19] and consequently may have exhibited a lower sensitivity to the screening questionnaires than would be found elsewhere. In addition, the clinic's patient population may not be representative of patients in other practices. Future studies in different locales would allow more conclusive investigation of the accuracy of conjoint screening questionnaires in individuals of varying age, sex, ethnicity and patterns of substance abuse.

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Necrotizing granulomatous cervical lymphadenitis associated with B lymphocyte abnormalities and a positive PPD reaction

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Sarcoidosis is a diagnosis often made by exclusion. We present a case of what we believe is sarcoidosis presenting as cervical lymphadenopathy. Complicating issues in this patient included B lymphocyte abnormalities, and a positive PPD reaction. The patient continues to be steroid dependent. This case illustrates the difficulties in diagnosis and management of sarcoidosis.*Wis Med J.1995;94(3):141-143.*

Granulomatous cervical lymphadenitis is a challenging problem for clinicians. Many cases represent sarcoidosis; however, the differential diagnosis is long and includes mycobacterial and fungal infections and granulomas associated with malignancies. Since there are no pathognomonic diagnostic features for sarcoidosis, the diagnosis is often made by exclusion.[1]

We present an instructive patient with insidious onset of cervical lymphadenopathy, and a reactive tuberculosis skin test, who failed to respond to antituberculous therapy, yet had a complete reduction of her adenopathy with corticosteroids. Complicating her diagnosis was the presence of lymphocytes showing B-cell neoplastic markers, but without histologic evidence of lymphoma. The diagnosis of sarcoidosis was made by exclusion, but as the following case illustrates, it can be difficult to establish with certainty.

Case report

A 59-year-old woman reported a 3-month history of progressive bilateral cervical lymphadenopathy associated with mild fatigue and depression. Her medical history included insulin-requiring type II diabetes, esophageal reflux, and osteoarthritis. Surgeries included a cholecystectomy and total abdominal hysterectomy with bilateral salpingo-oophorectomy. Medications at presentation included doxycycline, insulin, misoprostol, and piroxicam.

Physical examination demonstrated a woman who appeared her stated age. Examination of the neck demonstrated two large anterior cervical lymph nodes with no other peripheral adenopathy appreciated. The other components of the head and neck examination were normal, as were the neurologic, cardiopulmonary, and gastrointestinal examinations. Initial normal laboratory values obtained included chest X-ray, complete blood count, sedimentation rate, serum angiotensin converting enzyme, thyroid function tests, and urinalysis. A tonsillar biopsy had been performed at another institution because of a question of a tonsillar mass, but was interpreted as normal. Diabetic control was acceptable with a 6.7% hemoglobin A1C value obtained. Results of serologies for syphilis, HIV, brucellosis, Lyme disease, cytomegalovirus, toxoplasmosis, Epstein-Barr virus, histoplasmosis, blastomycosis, coccidiomycosis, and aspergillus were negative. A five-unit PPD was applied and demonstrated 10 mm of induration in 72 hours. C-reactive protein was elevated at 3.9 g/dL. A computerized tomographic scan of the neck demonstrated extensive cervical adenopathy with central necrosis being present in the enlarged lymph nodes.

Because of the concern of a neoplastic process, a fine needle aspiration of the cervical mass was attempted, but was nondiagnostic. Cervical lymph node biopsy showed extensive granulomatous lymphadenitis with areas of caseous necrosis being present. Results of stains and cultures for acid-fast and fungal organisms were negative.

The patient was given isoniazid and rifampin. Six weeks later, the patient reported progressive fatigue, had enlarging cervical lymphadenopathy, and low-grade fever.

The sedimentation rate had increased to 55 mm/hr and the patient was now anemic. A biopsy was performed on another cervical lymph node, which again demonstrated extensive necrotizing granulomas; results of fungal and acid-fast stains an cultures were negative. Cells recovered from the lymph node for flow cytometry consisted of a mixture of small to medium-size lymphoid cells. The majority of the cells were positive for CD19 and CD20 antigens and virtually entirely kappa light chain positive. Southern hybridization revealed a definite rearrangement of the immunoglobulin heavy chain and kappa genes; however, no lymphomatous process was evident histologically.

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A considerable discussion was undertaken with the various consultants regarding her diagnosis. Failure to respond to antituberculous therapy and negative culture results made the diagnosis of mycobacterial infection unlikely. The pathologic specimen was reviewed by a consultant who also saw no histologic evidence of lymphoma. Thus, the diagnosis of sarcoidosis was arrived at as a diagnosis of exclusion. The patient was started on 40 mg/day of prednisone, and in 4 weeks had complete resolution of her symptoms and lymphadenopathy.

Two years after diagnosis, daily low-dose steroids are still required to maintain her remission, but no other disease process to explain her cervical lymphadenopathy has emerged.

Comment

Is this process sarcoidosis? In a recent series, cervical lymphadenopathy was reported in about 50% of patients with sarcoidosis involving the head and neck.[2] Forty percent of patients with cervical lymphadenopathy had a normal chest X-ray results, 27% had a normal angiotensin converting enzyme level, and no cases of hypercalcemia were mentioned.

Sarcoidosis is believed to be a T cell mediated process. Forrester et al [3] detected a clonal expansion of V 1^+ T cells unique to a subset of sarcoid and lung bronchial alveolar lavage cells. Other T-cell receptor antigen clones have been reported in sarcoid patients indicating an unusual activation of the cellular immune system.[4]

The B-cell abnormalities detected in this case were part of a lymphoproliferative disease evaluation and taken in isolation would suggest a diagnosis of B-lymphocyte neoplasia; however, the histology and clinical course did not support a diagnosis of lymphoma.

Cossman et al[5] in their multi-institutional retrospective analysis of gene rearrangement documented false-positive gene rearrangements in 3.2% of patients sampled. These cases all had Epstein-Barr virus infections. How this relates to the current case is unclear as Epstein-Barr virus titers obtained had negative results; however, the interrelationship of this B-cell abnormality to the classic T-cell dysfunction described in sarcoidosis is intriguing.

Serum angiotensin converting enzyme is elevated in 75% to 90% of untreated patients with active sarcoidosis.[6] Elevated serum angiotensin converting enzyme has also been shown to be elevated in working coal miners,[7] and recently in the chronic fatigue immune deficiency syndrome.[8] The current case had a normal serum angiotensin converting enzyme level initially as did 27% of patients in Dash et al[2] head and neck sarcoidosis series. An elevated serum angiotensin converting enzyme level is helpful in sarcoidosis if present to follow disease activity and response to treatment.[10]

Is this process lymphoma? A concern in our patient has to be the sarcoidosis-lymphoma syndrome. This entity consists of sarcoidosis associated with lymphoproliferative disease, usually Hodgkin's lymphoma.[6] Patients with this syndrome tend to be older, have long-standing lymphopenia, tend to require corticosteroids more frequently, and demonstrate persistent disease activity. Our patient, although asymptomatic, still requires daily low-dose corticosteroids 2 years after the initiation of treatment. Long-term follow-up will be essential as patients with sarcoidosis-lymphoma syndrome may present with lymphoma 7 years or more after the diagnosis of sarcoidosis.

Is this process tuberculosis? A reactive PPD reaction was present in our case and several reports have emerged concerning the detection of *Mycobacterium tuberculosis* (MTB) DNA using polymerase chain reaction technique in sarcoidosis patients.[10,11,12,13] Fidler et al documented MTB DNA in three of six sarcoid patients by using the polymerase chain reaction (PCR). It was hypothesized that the organisms present were cell- wall deficient, explaining the negative mycobacterial cultures.[10] Another European report demonstrated MTB DNA by PCR in 10 of 20 sarcoidosis patients and DNA from other mycobacterial species in another 20% of patients. In this study, a false-positive rate of 9% was observed.[11]

Other studies show less evidence of mycobacterial DNA in sarcoidosis. Bocart et al[12] noted only 2 of 22 sarcoid patients testing positive for mycobacterial DNA by PCR and Ghossein et al[13] found no mycobacterial DNA in 10 well-documented cases of sarcoidosis.

The current case failed to improve with standard antituberculous therapy, and required high-dose corticosteroids for symptom resolution. This, we believe, reinforces the low likelihood of MTB or atypical mycobacteria being responsible for her illness.

The prognosis of patients with sarcoidosis tends to be favorable.[14,15] Forty-six percent of patients in a community-based series had chest X-rays reveal abnormalities only; 25% required corticosteroids, and 2 of 82 patients with sarcoidosis died in a 10-year follow-up period.[14] Hillerdal et al[15] analyzed 505 patients over a 17-year period, documenting four deaths felt due to sarcoidosis. In both series, the disease is felt to be self-limiting with the role of corticosteroid treatment questionable as chest X-ray revealed abnormalities in a large percentage of cases would revert to normal without treatment.

In summary, we present a case of necrotizing granulomatous cervical lymphadenopathy with marked constitutional symptoms, positive PPD reaction, and B-lymphocyte

abnormalities. The amount of necrosis demonstrated in the lymph node biopsy specimens was unusual for classic sarcoidosis; however, that diagnosis was made by exclusion and was supported by the clinical response to steroid therapy. Sarcoidosis-lymphoma syndrome is a consideration and the patient will be followed closely for this.

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Hypernatremic dehydration in breast-fed infants

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Three cases highlight the association between elevated breast milk sodium and hypernatremic dehydration in the infant. All three mothers, breast-feeding exclusively, had sodium levels in breast milk elevated significantly above normal. Severe hypernatremic dehydration in otherwise normal infants who are exclusively breast fed can be due to elevated sodium levels in breast milk. *Wis Med J.1995;94(3):143-145.*

A MOTHER'S CHOICE FOR nutritional support of her newborn has become an increasingly important decision. With the increase in frequency of breast-feeding it is important for physicians and nursing mothers to be aware of appropriate breast-feeding techniques and also of possible complications of breast-feeding.[13] The association between hypernatremic dehydration and elevated sodium content in breast milk may be more common than previously reported.[1-7] To highlight this association, we report three exclusively breast-fed infants who developed hypernatremic dehydration due to hypernatremic breast milk.

Case 1

A 13-day-old exclusively breast-fed girl had a 1-day history of poor oral intake and irritability. There had been no vomiting, diarrhea or fever. Physical examination revealed a cool, lethargic infant assessed to be 8% to 10% dehydrated by clinical estimation. The heart rate was 112 beats/min, respiratory rate 36 breaths/min, temperature 36.6°C. Her weight was 260 g less than birth weight. Pertinent physical findings were sunken anterior fontanel, dry mucous membranes and decreased skin turgor.

In the emergency room, she had several short episodes of bradycardia. Initial laboratory values included serum Na 177 mEq/L, Cl 140

mEq/L, K 4.4 mEq/L, HCO_3 14 mEq/L, BUN 105 mg/dL, Cr 2.8 mg/dL. Blood and spinal fluid cultures were obtained and antibiotics were given. A CT scan of the head was done because of concern over the infant's lethargic appearance and was read as normal.

She was rehydrated over 48 hours. The initial blood culture was positive for alpha-hemolytic streptococcus which was felt to be a contaminant; antibiotics were continued until results of repeat cultures were negative. Breast milk analysis on day two of admission showed sodium content to be 31 mEq/L (normal 7 ± 2 mEq/L). She was discharged on the seventh hospital day feeding well on a cow milk based commercial formula.

Case 2

An 8-day-old exclusively breast-fed boy had a 1-day history of lethargy and decreased oral intake. There had been no vomiting or diarrhea. Physical examination showed a crying and irritable male infant. His vital signs were temperature 35°C, pulse 92 beats/min, respiratory rate 20 breaths/min, blood pressure 72/40 mm Hg. His weight was 2.2 kg (birth weight 2.78 kg). The anterior fontanel was depressed, the mucous membranes were dry, and skin turgor was decreased. The remainder of results from the physical examination was unremarkable.

Initial laboratory values included Na 173 mEq/L, K 6.7 mEq/L (hemolyzed), Cl 131 mEq/L, HCO_3 14.1 mEq/L, BUN 22 mg/dL, Cr 1.2 mg/dL. Blood, urine and cerebrospinal fluid cultures were obtained. Intravenous antibiotics were given. The blood culture subsequently grew coagulase-negative staphylococcus, which was eventually determined to be a contaminant.

The infant was rehydrated over 48 hours. Maternal breast milk had a sodium content of 92 mEq/L. The infant was discharged on the sixth day tolerating a commercial milk based formula.

Case 3

An 11-day-old exclusively breast-fed boy with Down's syndrome had a 12-hour history of lethargy and poor feeding. There had been no vomiting, fever or loose stools. Examination revealed an alert but ill-appearing infant. Vital signs were temperature 36.6°C, pulse 120/min, respiratory rate 24 breaths/min, blood pressure 80/45 mm Hg. His weight was 3.04 kg (birth weight 4.03 kg). Physical examination showed the stigmata of Down's syndrome. There was a green discharge from the left eye. The skin turgor was poor and capillary refill time was 3 to 4 seconds. The remainder of results from the physical examination was unremarkable.

Initial laboratory values included Na 180 mEq/L, K 4.8 mEq/L, Cl 143 mEq/L, glucose 23 mg/dL, HCO_3 19.9 mEq/dL, BUN 75 mg/dL, Cr 1.6 mg/dL. A septic workup was done with cultures drawn from the blood, cerebrospinal fluid, urine and the left eye. Intravenous antibiotics were given. Breast milk sodium was 64 mEq/L.

The patient was gradually rehydrated over 48 hours. Antibiotics were discontinued at 48 hours when results from all cultures were reported to be negative. He was discharged on a commercial cow milk based formula on the sixth hospital day.

Discussion

The variable composition of breast milk has been known since 1949, when Macy found that there were significant changes over the first 1 to 2 weeks postpartum. Colostrum had more sodium, potassium and other electrolytes than mature milk.[12] For example, mature milk had 41% less sodium than colostrum.[8] Recent studies have confirmed the changing sodium content of breast milk during the first postpartum week.[1,9]

Koo and Gupta found that breast milk sodium the first day following delivery of both term and preterm infants was increased (sodium 64 ± 4.4 mEq/L for term breast milk and 70.9 ± 11.4 mEq/L for preterm breast milk) compared to breast milk sodium on the third day of life (18-24 mEq/L) and then continued to slowly decrease over the first month. By the 28th day breast milk sodium had decreased to 10.6 ± 0.6 mEq/L for preterm infants and 6.9 ± 0.2 for term infants.[1]

In addition to the usual causes, evaluation of the breast-fed infant with hypernatremic dehydration must include the possibility of increased intake of sodium due to hypernatremic breast milk.[11] Clarke et al first reported hypernatremic dehydration in an exclusively breast-fed infant in 1979.[2] Heldrich and Shaw concluded that breast-fed infants with hypernatremic dehydration due to high breast milk sodium were generally born to primaparous women and had a history of lethargy, poor feeding, and oliguria.[3] The hypernatremic infant was characterized as a healthy infant prior to the illness, who was quiet and content and did not cry when hungry.

Our three patients were neonates with decreased intake of hypernatremic breast milk. Their history suggests decreased oral intake without excess water loss. While dehydration alone can lead to hypernatre-

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mia, formula-fed infants with diminished intake do not usually develop hypernatremia. In the past hypernatremic dehydration in infancy was usually due to ingestion of boiled skim milk or excess sodium intake due to improper formula preparation. In our cases as well as in those previously reported decreased free water intake was complicated by the elevated sodium content in the breast milk.

It is unknown why breast milk sodium remained elevated in these mothers beyond the usual 3 to 4 days. Delayed milk maturation appears to be the best explanation for persistently elevated sodium levels. It has been suggested that since there is an inverse relationship between breast milk sodium and lactose, prolonged elevation of sodium levels in breast milk may be related to inadequate levels of lactose.[10] There is no known relationship between breast milk sodium content and maternal sodium intake.

Exclusively breast-fed neonates who have hypernatremia may be receiving breast milk with an elevated sodium level. In accordance with standard guidelines, ill-looking neonates are evaluated with blood, cerebrospinal fluid and urine cultures, and treated with empiric broad spectrum antibiotics pending the results of cultures. Initial management of these infants does not differ from other neonates with hypernatremia. Rehydration should occur slowly over 48 hours.

Mothers should be encouraged to pump breast milk to facilitate maturation. Breast milk sodium levels may be measured until the sodium content falls within the normal range. Although after recovery our patients were fed commercial formulas, breast-feeding may be resumed when breast milk sodium falls within the normal range.[4]

Conclusion

We describe three cases of exclusively breast-fed infants in whom the cause of dehydration was elevation of sodium levels in maternal breast milk. Awareness of this possibility should lead physicians and other practitioners to early identification and appropriate counselling concerning this problem. Although these patients were discharged on a commercial formula, advice was given on the advantages of breast-feeding and the possibility of returning to breast milk under the supervision of their primary physicians.

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A public service message

Public health

The costs of traumatic spinal cord and brain injuries in Wisconsin

Nancy E. Chudy, MPH; Patrick L. Remington, MD, MPH; and Joseph N. Blustein, MD, Madison

INJURIES ARE THE LEADING cause of death and disability in the Wisconsin among persons ages 1 to 44 years.[1] Of all injuries, traumatic spinal cord injuries and brain injuries are acknowledged to be among the most catastrophic. These injuries have profound effects on the public's health because of the young age of those injured, the high cost of acute and rehabilitative care, and the long-term disability.

Surveillance and assessment are core functions of public health. In this report, we estimate the health and economic burden of traumatic spinal cord and traumatic brain injuries in Wisconsin. This information will be useful for planning and implementing injury prevention programs and policies.

We obtained mortality data from the National Center for Health Statistics for 1979 through 1991, via the Wide-ranging ONline Data for Epidemiologic Research (WONDER). We identified underlying causes of death from deaths from spinal cord injury (*International Classification of Disease*-9th Revision (ICD-9) codes 806 (fracture of the vertebral column with spinal cord injury) and 952 (spinal cord injury without evidence of spinal bone injury) and traumatic brain injuries ICD-9 codes 800.0-

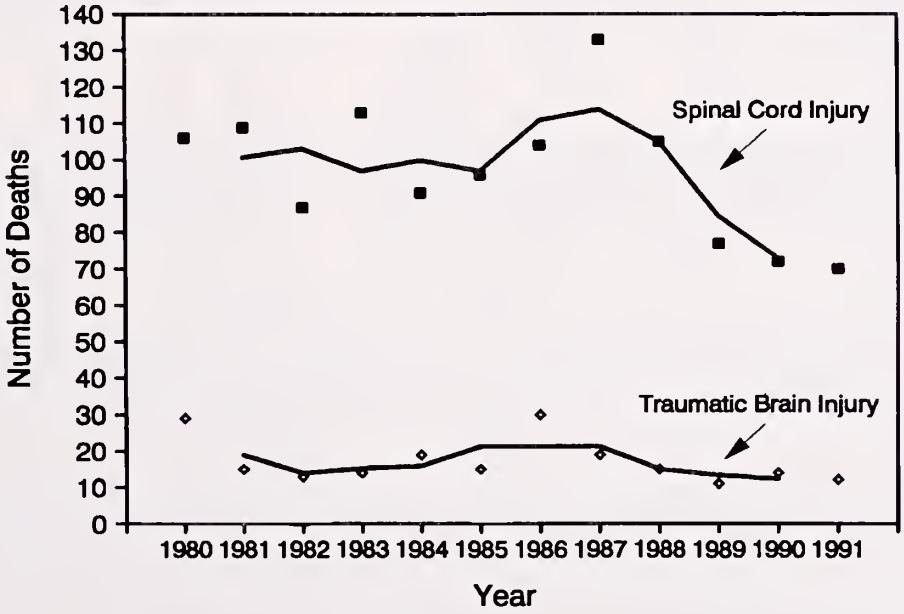

Fig.--Trends in spinal cord injury and traumatic brain injury deaths in Wisconsin, 1980-1991. The line represents a 3-year moving average.

The public health column is not reviewed by the *WMJ* Editorial Board. Dr Remington is chief medical officer in the Section of Chronic Disease and Health Promotion, Bureau of Public Health, Division of Health. Chudy is an epidemiologist in the Section of Chronic Disease and Health Promotion, Bureau of Public Health, Division of Health. Dr Blustein is an ophthalmologist and epidemiologist. Reprint requests to: Patrick Remington, MD, Wisconsin Division of Health, 1414 E Washington Ave, Madison, WI 53703-3044. Copyright 1995 by the State Medical Society of Wisconsin.

801.9 (fracture of the vault of skull, fracture of the base of the skull); 803.0-804.9 (other and unqualified skull fractures, multiple fractures involving skull or face with other bones); 850.0-854.9 (concussion, cerebral laceration and contusion, subarachnoid hemorrhage following injury without mention of open intracranial wound, other and unspecified intracranial hemorrhage following injury, intracranial injury of other and unspecified nature).

We obtained hospital discharge data from the Office of Health Care Information database for 1989 through 1993. The hospital discharge database is composed of continuous inpatient hospital discharge records of Wisconsin residents. We obtained information on treatment charges (hospital only, does not include physician charges) and length of stay. Information on the external cause of injury (E-code) was not available for all cases.

To limit the number of duplicative discharges (patients often require re-hospitalizations for these types of injuries), we used data-linking methods to eliminate admissions of the same person while maintaining the confidentiality of the records.

Mortality

The number of deaths from spinal cord injuries appears to be decreasing. Each year between 1980 and 1988, there were an average of 105 deaths from spinal cord injuries. Since 1989, only 73 deaths have occurred each year, a reduction of 30% (figure). During this same period, there were an average of 24 deaths from traumatic brain injury each year, ranging from a high of 30 in 1986 to a low of 11 in 1989, with no apparent trend over time.

Hospitalizations

From 1989 to 1993, the number of persons hospitalized with a principle discharge diagnosis of spinal cord injury decreased slightly, from 257 to 228 per year (table). The average charges per person increased over two-fold, from $34,000 to $77,000 per year, and the average length of stay increased from 27 to 34 days. The total charges for spinal cord injuries doubled, from $8.8 million to $17.6 million per year.

Information on the external cause of injury was available for only 48% of spinal cord injury cases. Among these, the leading causes of injury were motor vehicle crashes (39%), falls (30%), intentional violence (9%), and being struck by objects or persons (8%).

Between 1989 and 1993, the number of persons hospitalized with a principle discharge diagnosis of traumatic brain injuries decreased by a third, from 4,655 to 3,156 per year. The average charges per person, however, nearly doubled, from $8,000 to $15,000 per year and the average length of stay increased from 6 to 8 days. Thus, despite the lower incidence, the total charges for traumatic brain injuries increased by about one-quarter, from $37.4 to $47.7 million.

Information on the external cause of injury was available for 61% of traumatic brain injury cases. Among these, the leading causes of injury were motor vehicle crashes (35%), falls (34%), intentional violence (11%), being struck by objects or persons (8%), and bicycle crashes (5%).

Discussion

The data presented here show a decline in the number of persons hospitalized for traumatic brain injuries. This could represent a true decrease in the incidence of traumatic brain injuries, a tendency to

Continued on page 149

Trends in hospitalization for spinal cord injuries and traumatic brain injuries, Wisconsin, 1989-1993.

	Spinal cord injuries			Traumatic brain injuries		
Year	*Number of discharges*	*Average charge per person*	*Total charges per year*	*Number of discharges*	*Average charge per person*	*Total charge per year*
1989	257	$34,000	$ 8,800,000	4655	$ 8,000	$37,400,000
1990	263	$43,000	$11,400,000	4355	$10,000	$42,300,000
1991	223	$60,000	$13,500,000	3876	$11,000	$41,700,000
1992	242	$59,000	$14,400,000	3661	$13,000	$46,900,000
1993	228	$77,000	$17,600,000	3156	$15,000	$47,700,000
Change in 1989-1993	-11%	+126%	+100%	-32%	+88%	+28%

Source: Office of Health Care Information. Average charges were rounded to the nearest 1,000 and total charges to the nearest 100,000.

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Continued from page 147
treat less severe cases as outpatients, or both. In fact, the increase in the average length of stay suggests that persons with less severe injuries are less likely to be hospitalized in 1993. The recent decline in the number of deaths from spinal cord injuries, without a decrease in the number of hospitalizations, suggests that survival rates for persons with spinal cord injuries may have increased in the state.

Although traumatic spinal cord and brain injuries are less common than cancer and cardiovascular disease, the costs to society are disproportionately high.[2] Traumatic spinal cord injuries and brain injuries, along with accompanying paralysis, exact a high physical, emotional and economic toll for injured persons and their families. Persons who survive these extensive injuries require long-term health care treatment and rehabilitation. Persistent physical, neuropsychological, and psychological deficits often follow severe head injury. Difficulties in job performance, educational pursuits, and behavior are often manifested by these patients.

Acute hospitalization costs, as reflected by the hospital discharge data, are only the beginning of the extensive care required for a patient with a permanent disability. Physician fees, subsequent therapies, rehabilitation, transportation, physicians visits, attendant care, vocational rehabilitation, job training and education, have not been included in this estimate. The costs of acute hospitalization and rehabilitation associated with a single case of spinal cord injury has been estimated at $72,000-$153,000, and the lifetime direct costs at $210,000-$572,000. There are often lifetime earning losses as well, with injured persons often unable to perform their usual job responsibilities.[3]

Surveillance of spinal cord and traumatic brain injuries is a core function of public health. Such systems include information on risk factors, such as the circumstances surrounding the injury or the use of protective devices such as helmets or seat belts, as well as level of paralysis and functional capabilities of cases. In addition, some systems improve referral of injured persons into the rehabilitative networks, such as independent living centers or other services.

More than 20 states have initiated surveillance systems for persons with spinal cord and traumatic brain injuries. The information collected in these systems is essential for assessing the need for prevention, program planning and implementation, and assessing the effects of prevention programs.

Acknowledgments
Information for this study was provided to us by Bernie Tennis, in the Office of Health Care Information. This work was supported in part by a grant from the Developmental Disabilities Council of Wisconsin, and the Center for Injury Prevention and Control at the Centers for Disease Control and Prevention. We appreciate the support from the Spinal Cord Injury/Traumatic Brain Injury Advisory Committee, and the comments and suggestions of Tom Van Gilder, MD, and Susan Wood.

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Division of Health sends out fact sheet on reformulated gas

In response to current public concerns on reformulated or MTBE gas Dr. Henry Anderson, chief medical officer for state Environmental and Occupational Health, has sent out a fact sheet to Milwaukee area physicians. The Division of Health is investigating health complaints related to exposure to the gas and is urging individuals with severe symptoms to contact physicians. The Division of Health may be contacted at (608) 267-6844.❖

Working women and insurance

Michael J. Dolan, CLU, ChFC, Madison

NOW THAT MORE and more families have two breadwinners, how have family insurance needs changed?

Clearly, life insurance should be a first priority for anyone who earns an income. Yet often little thought is given to replacing a wife's salary even as a husband carries ample life insurance. In fact, although women on average earn three-quarters of what men do, they purchase only half as much life insurance. Whatever you earn, if your family needs your income and will find itself hard-pressed to get along without it, you should carry life insurance.

But how much life insurance should a working, married woman have? Look at what's left of your annual income after taxes and expenses (commuting, child care, clothing, etc). Multiply that amount by the number of years it must last, either until your youngest child reaches age 18 or, if you want to pay for some part of college costs, until that child reaches age 22.

If "Junior" is now 12 and $30,000 of your income goes to support the family, as an example, the total is either $180,000 (for 6 years) or $300,000 (for 10 years). Subtract any other insurance you may carry, including group insurance, and you've arrived at the amount of insurance you should buy.

The wife who does not work outside the home may also need life insurance, especially if there are small children and sizable costs involved in replacing her services as nanny, housekeeper, and chauffeur. To determine how much is needed, you can perform a similar calculation based on what it would cost to provide the necessary services until children are on their own.

Buying all or part of the necessary amount as term insurance will help you keep premium costs down. Your life insurance agent can help you find the right policy at the right price.

You may also want to consider disability income insurance to replace income lost because you are seriously ill or injured and unable to work for a lengthy period. The working wife may have some disability coverage on the job but chances are that it won't extend to cover the long-term.

Talk to your insurance agent about the individual disability coverage that will meet your needs. Consider:

- The amount of monthly benefit; most insurers limit benefits from all sources to no more than 60% to 70% of your gross salary.
- The definition of disability-- inability to perform your own occupation or any job--and whether benefits are paid for partial disability as well as for total disability.
- How long you are willing to wait for benefits to begin; longer waiting periods, if you can cover costs for a few months, can keep premiums down.
- How long benefits will continue. While shorter payment periods reduce costs, you really need disability insurance to cover your working years.❖

Dolan is with the national Association of Life Underwriters. He is also vice president and chief operating officer of SMS Insurance Services.

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The objectives approach to assessing quality care

by Sidney Shindell, MD, LLB, Milwaukee

The following is adapted from a presentation before the SMS Health Care Financing and Delivery, Aug 3, 1994.

Four of the previous speakers in this session indicated the need for data that would enable us to assess the quality of the care we render to our patients. As the final speaker in this session and a member of this commission, I hope that what I shall present will provide a rational basis for doing just that, ie show a way to provide data useful to assess quality care.

Over the years, I have had several occasions to try to address this question. The first was the time the Medicare Act was passed and there was great concern over hospital use and those attributes of health care providers needed to ensure that recipients of medical care would receive an acceptable level of services.

Under a jointly sponsored project, the Medical Society, the Hospital Council, and the Blue Cross organization of Western Pennsylvania, the Hospital Utilization Project

Dr Shindell is professor emeritus of the Medical College of Wisconsin in Milwaukee. He has served in a series of positions relating to assessment of health care for the Wisconsin Regional Medical Program, Health Service Data of Wisconsin, the Foundation for Medical Care Evaluation of Southeastern Wisconsin, and the Governor's White Paper Committee on Health Care Reform. Reprint requests to: Sidney Shindell, MD, Department of Preventive Medicine, PO Box 26509, Milwaukee, WI 53226. Copyright 1995 by the State Medical Society of Wisconsin.

Table 1 -- Definition of categories of reason for admission.

Newborn
All infants admitted to the newborn unit (nursery) whether born in the hospital or transferred for special care from another institution.

Obstetrics
Patients in whom delivery is expected to occur during the present episode of hospitalization.

Minor surgery
A patient admitted for minor (usually elective) surgery, or for invasive diagnostic procedures (eg, cardiac catheterization).

Major elective surgery
A patient admitted for previously scheduled major surgery, such as cholecystectomy and hernia repair. The patient is usually ambulatory and not acutely ill.

Major emergency surgery
A patient admitted immediately following major trauma and where major surgery is highly probable (eg, acute appendicitis, fractured hip, etc.)

Acute medical illness
The patient has been well and develops unexpected illness and need for hospitalization (eg, myocardial infarction suspect, gastric ulcer, stroke, etc.).

Psychiatric care
All psychiatric admissions, including drug overdoses.

Course of medical therapy
A patient is chronically ill and admitted for specific medical treatment of that disease. Includes such reasons for admission as recent deterioration, prolonged therapy requiring hospital control, readmission for postoperative complication, etc.

Supportive and terminal care
A patient has a known chronic disease and is admitted for care not involving specific treatment.

Work-ups
A patient is admitted for observation or for laboratory testing which cannot be performed on an walk-in basis.

came into being, and I participated in its early development.

When I came to Wisconsin to join the faculty of what was then the Marquette University School of Medicine, a similarly sponsored organization called Health Service Data of Wisconsin (HSD) was created and the Western Pennsylvania data system was transplanted to Milwaukee. At its peak, HSD monitored 33 hospitals and issued monthly reports on use patterns, mortality rates and other such data, but after about 5 years of operation there was little felt need to continue the service.

Not until about 2 years ago, when candidates for public office started pushing for a plan for universal health care, did some of the issues we began to deal with 30 years ago surface again. Primarily we hear concern over the manner in which we can maintain quality while remaining competitive by avoiding unnecessary services. Also, because of computer network capabilities, we hear of data systems that will facilitate information transfer, but I really don't hear anyone formulate the questions we need to answer as a basis for the data they propose to collect and disseminate. As a consequence, the data needed to assess objectively "quality of care" may not be collected. What I am trying to emphasize is that no matter how sophisticated a network system is, unless one puts the appropriate information in the appropriate form, there would not be the data present that we might wish to extract.

Last year, I was in Indonesia working with two of the medical schools in a project that was concerned with improving the manner of conducting their educational programs. At one of the schools, Airlangga University in Surabaya, I was asked to work with the department of medicine to try to build into their basic medical record a quality of care assessment mechanism. When I returned to the United States and became involved in trying to evaluate proposed data systems, I felt that some of our work in Indonesia might have applicability here. The essence of this presentation, then, deals with the underlying logic that resulted in the record we developed that was designed to collect the data we needed to assess quality care.

We started by asking the basic questions: How can one determine whether the care given to a patient is quality care? What kind of data would you need to measure or assure quality? At this moment in time, if a suitably qualified person gives or supervises the care given to a patient, we assume it is of good quality. In most cases it probably is - but how do we know? How could we measure it?

To try to answer this question, sometimes we measure such things as complication rates, post-operative infections, mortality rates, or disposition on discharge. We call these "outcome"measures, and we think we are assuring "quality" if the "outcome" is as expected. Sometimes we prepare "guidelines" and assume that adherence to guidelines insures quality. These are usually termed "process" measures. In both of these, we assume we know why care was given, and we assume that we achieved the results we were after.

What would happen, though, if when we see a patient, and assess his or her problem, we consciously state the reason why we are giving care? Shouldn't we also be able to state what we expect to achieve by giving care (outcome)? And what do we need to do to achieve our objective(s) (process)?

Let's look, then, at the reasons we render care. When we think about it, we recognize that generally people seek medical care because they are concerned over one or more of the following: physical discomfort, emotional problems, bodily dysfunction, and possible mortality.

Table 2.-- RFA category summary with major sub-categories

Newborn	major trauma
low birth weight infants	all other major emergency surgery
congenital malformations	**Acute medical illness**
all other newborn	myocardial infarction suspect
Obstetrics	congestive failure
false labor	respiratory illness
vaginal delivery	stroke
Cesarean section	GI hemorrhage
Minor surgery	phlebitis (deep veins of legs)
elective rectal surgery	gastric ulcer (uncomplicated)
all other minor surgery	alcohol
Major elective surgery	back problems
elective cholecystectomy	all other acute medical illness
elective herniorrhaphy	**Psychiatric care**
elective vascular surgery	overdose
all other elective major surgery	all other psychiatric admissions
Major surgical emergencies and trauma	**Course of medical therapy**
acute appendicitis	**Supportive and terminal care**
fractured hip	**Diagnostic tests not performable as an outpatient**
fracture of long bone	

DATA SHEET FOR QUALITY ASSESSMENT
INPATIENT

Case#_____ Adm. date_____ Disch. date_____
DOB_____ M/F_____ Ethn_____ Usual residence_____
Reason for admission: _____

Overall objective:_____

Problems* present on admission	Status of each on discharge
Laboratory studies performed	Information obtained
X-Ray examinations	Information obtained
Invasive diagnostic tests	Information obtained
Surgical procedures	Outcome
Medications given	Purpose
Complications during stay	Status of each on discharge
Time in ICU	Reason

Overall status on discharge _____
Degree of achievement of original objective _____
Reason(s) why original objective not fully achieved _____

Name of patient's physician:_____
Name of data recorder: _____
Date data recorded: _____

*A problem is a functional or pathological abnormality sufficiently serious as to warrant medical services

Fig 1. - Inpatient data sheet for quality assessment.

Thus, medical care, basically, has but four objectives. They are:

- to decrease or eliminate physical or emotional discomfort;
- to increase functional capacity;
- to increase the likelihood of survival; and
- to deal with inevitable mortality.

Quality medical care, then, can be defined as that care which:

- addresses the patient's concern;
- uses the most appropriate means to identify the functional or pathological abnormalities that give rise to the patient's concern; and
- uses the most appropriate means currently available to deal with these abnormalities.

In contrast to addressing patient's concerns or problems in a realistic manner, we all know that many people believe health care can do more than it is really capable of doing; much use of resources is directed at trying to achieve unachievable objectives; and this results in expenditures for activities that have questionable value.

If we wish to assure our patients that they can continue to receive appropriate (quality) care for their problems, and wish to do so at the lowest possible cost, I think we have to develop a data system that would enable us to distinguish between activities capable of affecting the problem being addressed, and activities (often costly) having questionable value or are totally ineffectual.

If we attempt to assess quality in the manner that I am suggesting, do we need to analyze cases on the basis of the 4000 plus diagnoses in the ICDA or the 400 plus DRG's? I believe we can do so by grouping cases much more simply, ie on the basis of the reasons for which care is given.

When we really think about it, there are only seven basic reasons why a person seeks health care services in a physician's office or clinic:

1. to get a preventive service;
2. because of an acute illness or injury;
3. because of a chronic categorical illness;
4. because of a chronic non-categorical illness;
5. because of the desire to have a risk appraisal;
6. to receive certification of health or illness; and
7. to receive counseling or reassurance.

If the services given during the initial visit do not dispose of the underlying concern, it may be followed by one or more additional visits for consultation or special tests, or for ongoing management.

I suggest that for each of the

DATA SHEET FOR QUALITY ASSESSMENT
OUTPATIENT

Case#_____ Date of initial visit_____
DOB _____ M/F_____ Ethn_____Usual res._____
Reason for initial visit:_____
_____
Was objective achieved on initial visit? Yes___ No___

If subsequent visits, number for:
Additional diagnostic tests_____
Management of ongoing problem _____
Counselling_____
Date episode of illness began _____

Problems* identified Current status
_____ _____
_____ _____

Date episode of illness resolved _____
(If care is still ongoing, so indicate)

Objective for care given _____
Degree to which this objective was or is being achieved _____
_____
Reason why objective not fully achieved _____
_____

Name of patient's physician: _____
Name of data recorder: _____
Date data recorded: _____

* A problem is a functional or pathological abnormality sufficiently serious as to warrant medical services.

Fig. 2 - Outpatient data sheet for quality assessment.

above reasons for care, a specific objective is to be achieved and the resources needed can generally be projected prior to the rendering of service.

We also have patients return for post-recovery observation, but I am not sure whether this is more for our emotional well-being than for the patient's benefit--unless, that is, we use the occasion to advise the patient on behavior modification that reduces the risk of future disease. This is now being advocated increasingly and is being termed "clinical prevention."

Just as is the case with outpatient care, there are really only a limited number of reasons why people get admitted to a hospital:

- to be born;
- to give birth;
- to have minor surgery;
- to have major elective surgery;
- because of a surgical emergency or trauma;
- because of an acute medical illness;
- to get psychiatric care;
- because of an ongoing or intermittent medical condition;
- to get supportive or terminal care; and
- to have diagnostic tests not performable as an outpatient.

These are defined as shown in Table 1.

In each instance, again, there is a specific objective to be attained and the resources needed to achieve that objective are generally predictable at the time of admission.

If one wishes to focus in on specific entities, there are relatively few of sufficient frequency that can be looked at separately. What has been found is that patients with either the 10 most common diagnoses or the 10 most common surgical procedures account for half of the total case load. To have sufficient numbers for the remainder of analysis, one has to group them in some fashion. The question is, how to group them on some sort of logical basis. This is what DRG's are about, but many question the basis for much of their groupings, since they group on the basis of diagnosis, not on the basis of the services the patients require.

What is contained in Table 2 is a grouping developed by Dr Erwin O. Hirsch, a former faculty member at the Medical College of Wisconsin. He came to the college from Princeton Hospital where he had worked on the problem of assessing quality of care, and he made his work available to a research organization with which I was associated, under terms that enable me to make his work available to you here.

For each of the categories of patients shown on Table 2 (or for that matter, for each patient that we care for), what kind of data do we need to reflect that the care given contributed to the attainment of our objectives and was the suitable modality to do so?

Figure 1 is a sample form that contains what we think is required, could be placed in the patient's record, and could be dealt with in the same confidential and privileged manner as are other data relating to professional standards review.

A somewhat similar form could be developed for outpatient care as well, and a sample is shown in Figure 2. Please note, this form deals with episodes of care, not each visit.

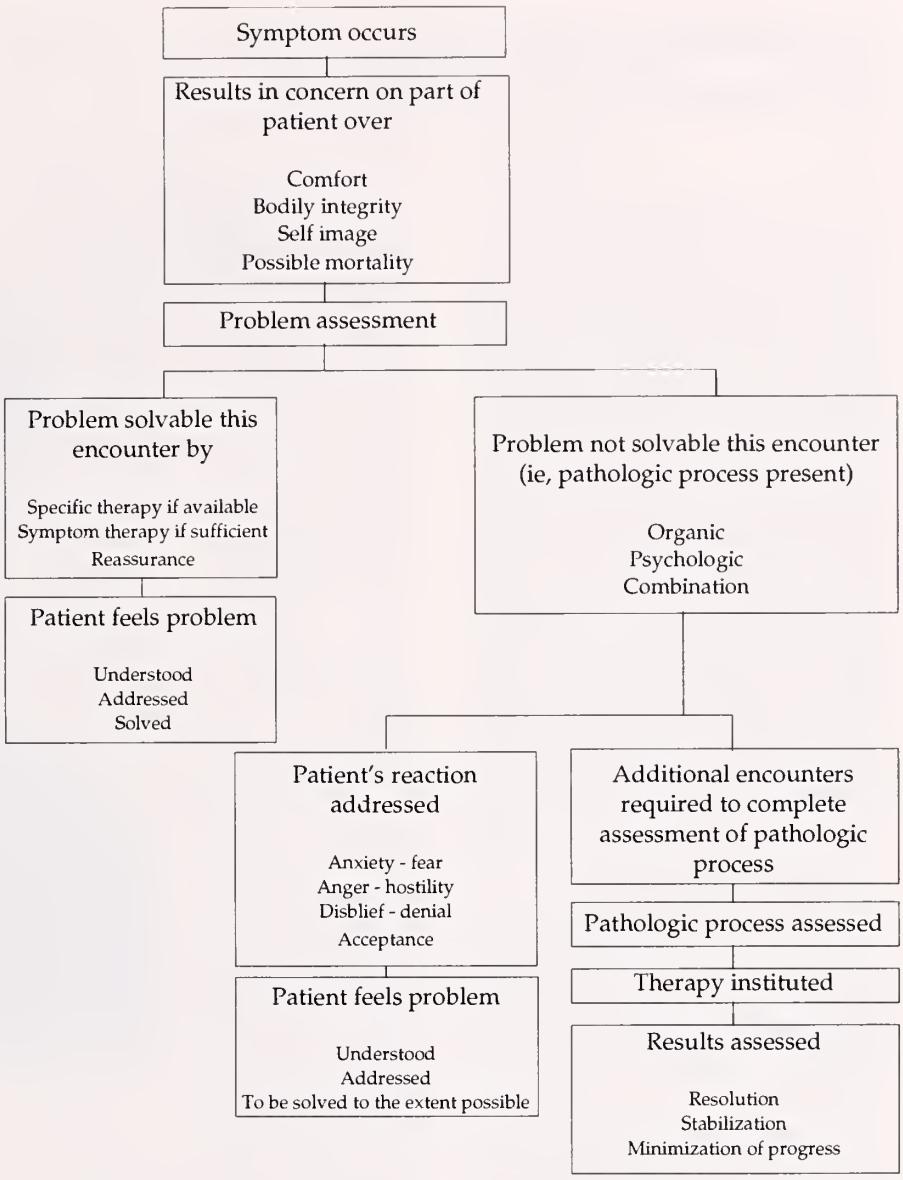
This is to keep record keeping at a minimum, and to place everything in the context of what is the objective of care and how services relate to achieving that objective.

What the data reflects is whether: the problems presented by the patient were correctly identified; the most appropriate means were used to identify them; and the most appropriate means were used to deal with them.

The logical basis for doing so is shown in Figure 3. This is reproduced with permission of the publisher. It originally appeared in a textbook published quite sometime ago and shows the components which make up the physician-patient encounter. It assumes only that the patient is conscious and rational. If the patient is not capable of active participation in his or her care, then someone has to be active in the patient's behalf.

For those who wish to include the patient's (or family's) reaction as a measure of quality in addition to concentration on preset objectives, this model shows how these are dealt with in parallel and are not at all inconsistent with each other.

The technique that has been presented here is not carved in stone. The material can be modified as a particular hospital staff or specialty group might wish. The items that are presented show, however, how one might design a data system that would contain the information needed to enable one to assess objectively the suitability of the care that was given, for whatever use we might wish to use this information.



I submit to you the following:

- Unless one actually collects data on objectives, degree of attainment, diagnostic procedures performed, information obtained therefrom, the therapeutic modalities, and the results obtained, I can see no way to assess quality.
- I have not seen any data system currently being recommended that collects the information needed to assess quality of care in these terms.
- If one wishes to develop guidelines, an objective basis for evaluating their suitability would be created by the collection of the data present on these forms.

I obviously feel that if the medical profession is to have any control over the way medicine is to be practiced in the future, we cannot permit control to be established by economic data that is collected to facilitate billing and reimbursement without our having parallel data on the efficacy of each activity in solving our patient's problems.

I do not believe our State Medical Society should endorse or accept any information system that does not contain an objective way of reflecting the services we render so that we may, on an ongoing basis, assess the efficiency of each of our services. How else can we assure quality and provide a means for improving medical care in the future?❖

Farewell to a friend: J D Kabler, MD, 1926-1995

The following comments were offered at a memorial service for J D Kabler, MD, in Madison on March 7,1995.

Cyril M. "Kim" Hetsko, MD

JD: We love you! A giant of a person! A great physician! A genuine friend!

There were no town and gown boundaries for this physician as he rose above such distinctions.

J D was my mentor for almost 30 years, starting when I was an intern and continuing through residency, the military, the Dane County Medical Society, the State Medical Society, the North Central Medical Conference and more than two dozen meetings of the American Medical Association House of Delegates that we attended together. With a flash of a smile, J D would be quick to point out that this meant the endurance of many rubber chicken dinners and mystery meat banquets.

A true medical statesman, he practiced the highest of ethical principles for the profession that he loved. He was ahead of his time, being very encouraging of the participation of women and minorities in medicine, and the creation of health care delivery entities such as the "Blue Bus Clinic" for sexually transmitted diseases and the university student health service prepaid health coverage (what would be called an HMO today).

In recent years, J D would get that special twinkle in his eyes, smile on his face, and tilt of his head, and then express the great pride in the various interests that had been such an integral part of his life. He was especially proud that people would be able to flourish in their own right, and he had that sense of fairness which would encourage this individual development.

J D shared a lot of important parts of himself with many of us. He often expressed being proud of his plains heritage from Kansas and his pride of service in the military and community service organizations.

He was proud of having been a professor and teacher (especially mentoring the current third-year medical school class that had become so important to him).

He taught us by his sense of professionalism (including chairing the Medical Society Ethics Committee and Interprofessional Relations Committee with the Bar Association).

J D Kabler, MD

He shared his expertise by helping his patients.

He was a role model and he demonstrated his deep-rooted principles of ethical behavior, and his intense pride and sense of responsibility of being a physician (and everything that that implied).

Very importantly, he would reflect on how proud he was of his five children. Most especially, J D was proud to have shared his life with his partner of many years, Bea.

Very clearly, all of us who knew J D Kabler have been enriched by him, and a part of J D will continue in all of us.

I think J D might appreciate a small quote from Oliver Wendell Holmes, MD, (the physician father of the famed Supreme Court jurist): "I find a great thing in this world is not so much where we stand as it is in what direction we are moving: to reach the port of heaven, we must sail sometimes with the wind and sometimes against it--but we must sail, and not drift, nor lie at anchor." J D was the ultimate sailor.

As J D would say with a smile on his face after hours of long-winded rhetoric at a medical meeting, "It's time for me to retire and press my shoelaces."

J D, we love you.

And more importantly, for having shared him with us, to the Kabler family, we love you.

Thomas L. Adams, CAE

During Dr Kabler's term as president of the State Medical Society, we at the SMS began calling his one-liners and pithy axioms "Kablerisms." And one of my favorite Kablerisms was "How you stand depends on where you sit." I think he'd be pleased to see us sitting here today with his family and loved ones. It says something about where we stand on what is important in life.

We are here to celebrate a life that has ended, and to honor all that was the man who lived it:

- compassion and character
- insight and intelligence
- leadership and love
- dignity and depth
- humility and humor
- eloquence and exuberance
- wisdom and wit.

A life so fully lived exceeds my store of adjectives, so I will rely instead on awe. I first knew Dr Kabler as a physician--a true giant in medicine--but he was so much more that I quickly learned to look to him as a mentor and to treasure him as J D, my friend.

The one thing I know about J D that many of you may not is that he was a medical meetings aficionado. It seemed he attended more than anyone, but still could not get enough. As you might imagine, such meetings can sometimes be less than exciting, keeping minutes but wasting hours. Without fail, however, the drooping heads righted and the heavy eyelids opened when J D rose to speak.

Regardless of whether you agreed with what he was saying, you wanted to hear it said. You knew his points would be well thought out, his logic flawless and his oration a work of art. His presentations were always the highlight of any meeting, and few of us will ever hear a more gifted speaker.

J D was a giant in life, too: cherished by his wife, Bea; loved by his children and grandchildren; admired by his colleagues; emulated by his peers; sought after by his students; trusted by his patients. He moved through life with uncommon grace and uncommon strength--a combination that made him as formidable as he was enchanting.

Over the years, I have met and enjoyed a host of wonderful people. For some, I have come to know profound affection, and the time I spend with them is priceless. But whenever I was with J D, I felt like an apprentice at life--a most fortunate apprentice to have him as my counselor. To spend time with him was not enough. I felt compelled to learn from him, to be more like him. He was more than an example of how a human life might best be lived, he was an inspiration.

Another of J D's famous "Kablerisms" was his formula for a successful speech: "Point to the past with pride, view the present with alarm and look to the future with confidence." I think we can use that formula today.

Pointing to the past, we happy few are proud to have shared this life with him, and we are better for it. Viewing the present with alarm, his passing feels to me like the ceasing of some exquisite music. But looking to the future, we are grateful for the image of humanity he has left us. His hopes and his ideals, we commit to our minds and our wills. His loves we commit to our hearts. And his body we commit to its natural end.

In the words of the poet Shelley: He is made one with nature; there is heard / his voice in all her music, from the moan / of thunder, to the song of night's sweet bird; / he is a presence to be felt and known / in darkness and in light... / He is a portion of the loveliness / which once he made more lovely.

H. B. Maroney, II, JD

Like all of you, I have spent the past few days thinking about Dr Kabler's relationship with many of us, and about how truly saddened, but honored, I am to be here.

As I was trying to figure out how to capture a favored and treasured friend, I kept thinking he would say, "Bernie, if you don't have anything to add, don't.:

But, JD, I do...

All of us know you loved words and we haven't used one that for me, taken in its true meaning, personifies your life. That word is "frugal."

In our current lexicon it is not a popular word, but when you delve into its root and historic origin you find that it really means: enjoying the virtue of getting good value for every minute of your life energy and from everything you have the use of, or: one who has the virtue of knowing what he possesses is enough and who gives and gets full value and life's joys from using his possessions for what is important to him and those he cares for.

You, Dr Kabler, were frugal. You knew you had enough and you enjoyed what you had.

You loved:

- being the "aw shucks" guy from Kansas
- relating to Watercress, Wisconsin
- your education and the opportunity to continue it on a lifelong basis
- your family
- your friends
- your community, which you vowed never to leave because "I like it here and I hate those adult playgrounds."

You enjoyed bringing sometimes contentious groups together--such as nursing and medicine in the Joint Practice Committee, and doctors and lawyers in your leadership of the Interprofessional Code Committee of the Bar and Medical Society.

You enjoyed and received full value from your professional efforts as long as they benefitted the art and science of medicine, its practitioners and, most of all, its students and patients.

Yes, you were frugal because you had the virtue of knowing what was

needed, but also knowing when "enough is enough." You explained to many of us the futility of "rearranging the deck chairs on the Titanic."

You gave of yourself, not because you had to but because you wanted to. You never tried to build great wealth or a long resume–just enough would satisfy. You were comfortable with yourself and what you had and you enjoyed using your talents and resources for causes and people you believed in.

So, in your philosophy, let me be frugal with words and summarize by saying that my personal faith makes me believe that you had more than enough (in your words) "tickets for the starting gate."

Based on your virtue of knowing how to use your resources for others and knowing how to enjoy while giving, I am certain you have already been tapped to be on the Medicine and Ethics Committee at a new gate.

Be assured all of us will often thank you for what you taught us and for being a friend.

Yes, JD, in your honor this is a frugal tribute, for I do know it is Tuesday and, after all..."Tuesday is a school night."❖

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Dr Scott presents papers at national environmental health meetings

Shari Hamilton, assistant editor

Pollution is more than just a dirty word to Madison physician John K. Scott; it's a global health issue that has great impact on the way this generation and future generations will live out their days. A past SMS president, Dr Scott serves as sole US delegate from the National Association of Physicians for the Environment (NAPE) to the International Society of Doctors for the Environment (ISDE). As part of these responsibilities Dr Scott travels to meetings across the globe where physicians gather to increase awareness of pollution, highlight concerns and empower local change.

Physicians from across the country convened recently at the National Press Club in Washington to discuss the effects of air pollution on body organs and systems, according to Dr Scott.

The NAPE conference was the first ever to deal with the affects of air pollution on all organs and systems of the human body and to specifically discuss the effects pollution has on minorities, children, and senior citizens. Fifty of the conference's 100 seats were reserved for medical and environmental media.

The NAPE charter calls for the organization to work with national medical specialties and subspecialities, with national, state and local medical societies, with individual physicians, and with other health care professional and voluntary organizations to address the effects of environmental pollutants on health. The slate of experts include noted specialists from the American Society of Hematology, the National Institute of Diabetes and Digestive and Kidney Diseases; the American Academy of Dermatology, the National Institute of Allergy and Infectious Diseases, the Dept. of Urology at Mount Sinai Medical Center-NYC; the National Institute of Environmental Health Sciences; the Centers for Disease Control; the Environmental Protection Agency; and many others.

Dr Scott, immediate past chair of the AMA Long-Range Planning Committee, discussed: the effects of pollutants on health; populations who face increased health risks; ozone depletion and the phasing out of halocarbons; industrial and transportation-related emissions; and efforts underway to reverse pollutants.

"Of the world population, 564 million people---including large populations in Europe and Eastern Block nations, live in areas that fail to meet US standards for six common air pollutants: sulfur dioxide, carbon monoxide, nitrogen dioxide, ozone and lead," Dr Scott said. "A national health objective for the year 2000 is to reduce exposure to air pollutants so that at least 85% of humanity lives in countries that meet US environmental protection standards."

The Washington meeting followed a September 1994 international scientific symposium. Topics there included: biochemical processes of environmental pollution; effects of chemicals and food additives on the immune system; hidden assumptions in environmental research; radiation of food; contamination of food by heavy metals; organic halogenated substances in food and mother milk; contamination of food by pesticides; food toxins; genetically engineered food; environmental food contamination; and infertility by environmental pollution.

John K. Scott, MD

Dr Scott, who is also a Madison otolaryngologist, reported that the ISDE network has grown to include associations in 28 nations and doctors in more than 100 nations on all five continents. ISDE acts as a coordinating body between the different associations as a stimulus, and circulates information and knowledge with the aim of restoring an environmental situation which is worsening each day, Dr Scott explained.

At a recent ISDE meeting, Dr Scott presented a paper discussing environmental conditions contributing to food contamination.

"The agents causing food-borne infections are more numerous than ever," Dr Scott noted. "These illnesses are widespread, unreported and potentially dangerous, especially to the old, young and immunocompromised.... Until a few years ago, a relatively small number of pathogens were thought to cause the diarrhea, nausea, vomiting and

Continued on next page

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abdominal pain of food-borne illness. Many new pathogens have emerged, however, and microorganisms not previously incriminated have been found to be transmitted in food. Today we also recognize that some food-borne infections may cause life-threatening conditions such as hemolytic-uremic syndrome and Guillain-Barre syndrome."

Among reasons for increased contamination, Dr Scott said, are greater consumption of contaminated fresh produce; central food processing which increase potential for widespread contamination thwarts detects of outbreaks and complicates investigation; and preparation of food by people not experienced with proper handling requirements.

Very young, very old, pregnant, diabetic or immunosuppressed populations face the greatest risks. According to Dr Scott, food-borne illnesses each year probably affect as many as 80 million Americans, cause as many as 4,000 deaths and cost up to $23 billion in medical costs and lost productivity.

Adequate safeguards generally exist to prevent foods from becoming contaminated via environmental mechanisms, Dr Scott said. There is a need, however, he said, to increase knowledge and precautionary measures concerning the levels of undesirable chemical contaminants that will provoke adverse and serious responses in humans.

ISDE meets four times per year, each meeting at a different location to increase global awareness of pollution problems. Dr Scott presented a paper earlier this year in Poland. He will represent the United States at ISDE meetings in Brazil in August and in Italy in November. ❖

House of Delegates to consider nearly 60 policy resolutions

When the SMS House of Delegates convenes Friday, April 7, in Lake Geneva, physician delegates from across the state will be weighing the merits and demerits of 58 resolutions, 23 board recommendations, and one constitutional amendment. Resolutions are divided into four categories: state and national issues; socioeconomic issues; scientific activities and organization and finances. Reference committees on those subjects will be chaired by the following physicians, respectively: James Siepmann, MD, Oshkosh; Charles Link, MD, La Crosse; Dean Stueland, MD, Marshfield; and James Concannon, MD, Kenosha. Dr Ed Matthews, of Milwaukee, will chair the credentials committee. Policy issues under consideration refer to issues involving physician assisted suicide; mandatory binding arbitration in medical malpractice cases; the death penalty; physician choice in HMO plans; and managed care reimbursements based on quality care. Delegates will also be asked to consider resolutions on such topics as the medical outcomes research project, creating a section for cardiothoracic surgery and medical society involvement in specific antitrust lawsuits.

Sessions

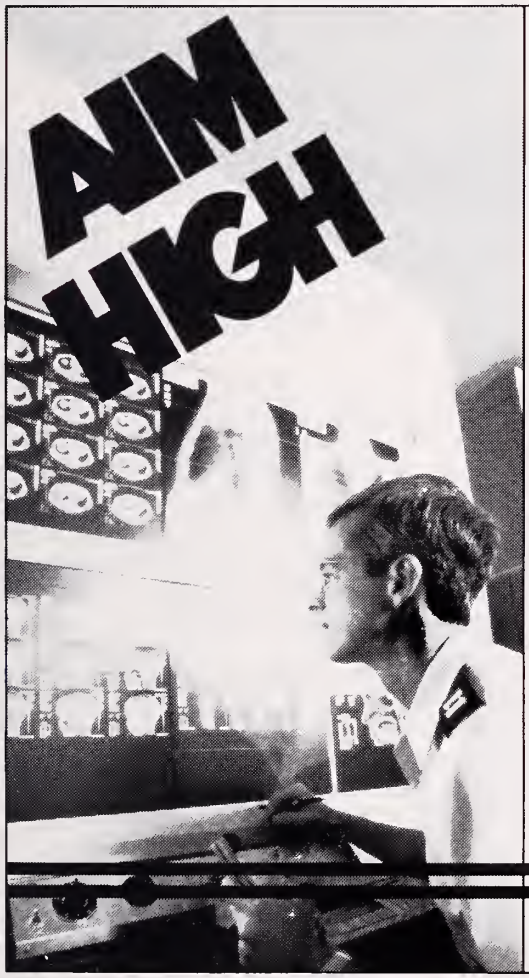
Speaker Sandra Osborn, MD, of Madison, will convene the first session of the House of Delegates April 7 at 4 PM. Reference committees will meet April 8, beginning at 8:30 AM. The second and third sessions of the House are planned for 3 PM. April 8 with the final session of the House set to begin Sunday, April 9, at 8 AM.

Spouses, families welcome

Families are welcome to join SMS members in attending this annual meeting. The convention center offers a full spa and sport center, stable and children's activity program. Childcare will be available for younger children and there will be evening children's activities. To make reservations, call: Grand Geneva Resort and Spa at (414) 248-8811 or 1-800-558-3417 and request your room be held under the State Medical Society group. Hotel rates are $88 single or double occupancy.❖

Wisconsin kids to launch march on Capitol, seek stronger anti-tobacco laws

About 1,300 Wisconsin students, representing 40 high schools from across the state, will march on the Capitol April 5 to ask lawmakers to strengthen tobacco laws and increase the cigarette tax. The march will be part of a full-day Kids at the Capitol event, sponsored by the Tobacco-Free Wisconsin Coalition, of which the SMS is a member. SMS President Richard G. Roberts, MD, JD, of Madison, will preside over a noon rally on the Capitol steps, celebrating this generation of "smoke-free kids." Sen Carol Buettner and Rep. Peter Bock, both strong health advocates, will also participate. Students will attend educational break-out sessions and visit lawmakers throughout the day. Current legislation under consideration calls for a 50-cent increase in the state's cigarette tax and increased enforcement efforts of the laws prohibiting merchants from selling tobacco products to minors.❖



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AIR FORCE

SMS registers concerns over MA administrative changes

THE SMS HAS REGISTERED its concerns over aspects related to the state Medicaid program's contracting process for the next Medicaid fiscal agent. Requirements for the new fiscal agent, which will be announced later this month, include wide-ranging changes in how the $2.5 billion-a-year program is administered.

Among those issues are: to include a "Nurseline" protocol for Primary Provider Program-type patients; a "vast expansion" in the use of sophisticated "artificially intelligent" computer systems to process claims; the extent to which electronic claims submission is required; and the extent to which "magnetic strip" patient ID card technology would be necessary for physicians to process a plastic patient ID card.

Among the points the SMS made in the letter are: the SMS requested in detail the nature of the clinical guidelines that any such "Nurseline"would use; the SMS expressed strong opposition to any system that substitutes computer processes for the physician's medical judgment; and the SMS clarified that there will be no requirements for physicians to submit claims electronically as a result of the fiscal agent contract.❖

Fort Crawford museum to host first arts and crafts fair; artists sought

THE FORT CRAWFORD Medical Museum is inviting Wisconsin physicians and interested others to submit an entry for the first annual "Old" Fort Crawford Arts and Crafts Fair, to be held Sept 3 in Prairie du Chien. Artists who wish to participate are asked to complete a registration form and send it with three slides or photographs of their work, a self-addressed business size envelope, and $30 per space to the CESF no later than April 15. Exhibitors are encouraged to demonstrate their craft or art during the show. To receive a registration form, please contact the foundation office at 1-800-362-9080 or Delores Igou in Prairie du Chien at (608) 326-6960. The fax number is (608) 283-5401.❖

SMS Annual Meeting April 7-9, 1995

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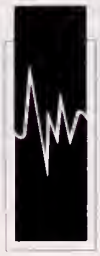

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Physician briefs

The * indicates a member of the SMS.

John D. Adolphson, MD,* has transferred his practice to the Colby-Abbotsford Center. Dr Adolphson received his medical degree from the University of Minnesota Medical School in Minneapolis and completed a family practice residency at Hennepin County Medical Center in Minneapolis.

Paul Barkhaus, MD, has been appointed associate professor of neurology at the Medical College of Wisconsin and director of neruomuscular disease at the Veterans Affairs Medical Center-Milwaukee. He will also serve as coordinator of the electromyography fellowship program in the department of neurology. Dr Barkhaus served as assistant professor of neurology at the University of Minnesota, director of the eletromyography laboratory and director of the EMG fellowship training program at the Minneapolis Veterans Administration Medical Cener.

Patricia Barwig, MD,* has been appointed chair of the OB-GYN department committee at Elmbrook Memorial Hospital in Brookfield. She is a shareholder with OB-GYN Affiliates, SC, in Brookfield.

Richard Boxer, MD,* has been appointed to the Medical College of Wisconsin's Health Policy Institute Advisory Board. Dr Boxer is a urologist in Milwaukee, and is chair of surgery at St Michael Hospital and past president of the Milwaukee Urological Society. He is a cum laude graduate of the University of Wisconsin School of Medicine.He completed his residency training in urology at UCLA Medical Center.

Laura V. Calderwood, MD, has moved to her permanent location at the new Mercy Walworth Medical Center. Dr Calderwood comes to

Continued on next page

S. Michael McGarragan
Attorney at Law

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Memorial Hospital at Oconomowoc
Waukesha Memorial Hospital

Continued from preceding page
Wisconsin from Spokane, Wash, where she was on the medical staff of Sacred Heart Hospital since 1986. She earned her medical degree from the University of Iowa, in Iowa City, and completed a psychiatric residency at the University of Iowa Hospitals and Clinics.

Edward P. Callahan, MD, will serve as medical director of Emergency Medical Services for Mercy Health System. Dr Callahan is assistant director of the Department of Emergency Medicine at Mercy Hospital and Medical Center in Chicago, as well as clinical assistant professor of emergency medicine for the University of Illinois program in emergency medicine. He also serves as assistant residency research director at Mercy in Chicago. Dr Callahan is a fellow of the American College of Emergency Physicians and serves on the Government Affairs Committee of Illinois Collee of Emergency Physicians. He received his medical degree from the Univesity of Illinois.

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MILWAUKEE

Jeffrey Goodwin, MD,* has recently joined the staffs of Midelfort Clinic and Luther Hospial. A graduate of Massachusetts Institute of Technology in Cambridge, Dr Goodwin received his medical degree from Case Western Reserve University School of Medicine in Cleveland, and performed his residency in diagnostic radiology at May Clinic in Rochester, Minn. While at Mayo, he also completed a fellowship in neuroradiology.

John Grych, MD, has joined the staff of Southeastern Wisconsin Medical &Social Services, Inc., an outpatient mental health and substance abuse treatment clinic. He is currently an assistant professor in the psychology department at Marquette University. He received his medical degree at the University of Illinois-Urbana-Champaign.

Cyril M. "Kim" Hetsko, MD,* has been elected president-elect of the North Central Medical Conference. The organization represents physicians in Wisconsin, Minnesota, Iowa, Nebraska, North Dakota and South Dakota.

Marvin Klingler, MD, has joined the Ramsey Clinic in Baldwin. He comes from Prince Albert, Saskatchewan, where he has been in practice at the Prince Albert Medicine Clinic. He earned his medical degree in 1984 from the University of Saskatchewan in Saskatoon and completed his residency in the Department of Family Practice at the University of Saskatchewan.

Yungho Lee, MD, board certified in internal medicine and gastroenterology, has joined the staff of the Mercy Walworth Medical Center. Dr Lee completed a fellowship in gastroenterology at Nassau County Medical Center, East Meadow, NY, and a residency in internal medicine at the University of Medicine and Dentistry of New Jersey, Robert Medical School. He received his medical degree from New York Medical College in Valhalla, NY.

Kathleen M. Meyer, MD, joined the staff of the Marshfield Clinic. She received her medical degree from the University of Michigan Medical School in Ann Arbor. She served her residency in general surgery at Waterbury Hospital Health Center in Waterbury, Conn, and in plastic and reconstructive surgery at the UW-Madison. She completed a fellowship in hand and microsurgery at the University of Pittsburgh.

John H. Neal, MD, has joined the Marshfield Clinic. He came from the University of California Irvine Col-

lege of Medicine in Orange, Calif. He earned his medical degree from Yale University School of Medicine in New Haven, Conn. He served his residency in neurosurgery at Los Angeles County-University of Southern California Medical Center in Orange.

Stephen Paulk, MD, a board-certified general surgeon, has joined the staff of Divine Savior Hospital and Nursing Home, Inc. Dr Paulk is currently in private parctice in Waterloo, Iowa. He received his medical degree at the University of Iowa in Waterloo. His residencies were in urology and general surgery.

Kevin Rak, MD, board-certified radiologist, will be joining the staff of Divine Savior Hospital and Nursing Home, Inc. He received his medical degree from the Medical College of Wisconsin in Milwaukee. His radiology internship and residency were done at the Fitzsimmons Army Medical Center in Aurora, Colo.

Mark Rosen, MD,* has been appointed assistant professor of surgery, division of urology, at the Medical College of Wisconsin. He practices at Froedtert Memorial Lutheran Hospital, where he specializes in urologic oncology. Dr Rosen completed his residency in urology at Baylor College of Medicine in Houston and general surgery residency at Harbor-UCLA Medical Center in Torrance, Calif. He received his medical degree from the University of California.

Robin Stickney, MD,* has joined the Mercy Walworth Medical Center and MercyClinic East. He is an occupational medicine specialist, and a former attorney with an emphasis in health law. Dr Stickney earned his medical degee from the Indiana University School of Medicine, and continued his education at the USAF School of Aerospace Medicine. An aeronautical rating flight surgeon, Dr Stickney also served as chief of professional, aeromedical and emergency services.

Charito M. de la Torre, MD, has joined the staff of Aurora Medical Group in Kenosha. She is a pediatrician who specialized in allergy and immunology. She was previously affiliated with the Lake County Medical Group and Great Lakes Naval Hospital in Waukegan, Ill. She completed her residency in pediatrics at Cook County Hospital in Chicago.

Jeffrey D. Winkoski, MD, has joined Waukesha Medical Centers-New Berlin, as a board-certified family medicine physician. He graduated from the University of Texas, and completed his family medicine residency at Mercy Medical Center in Denver.

Lawrence G. Wong, MD,* rheumatologist and internal medicine specialist, recently joined the staff of Mercy Clinic East. He has served as a rheumatologist in West Covina, Calif, and assistant professor of medicine at Loma Linda University Medical Center. He was a physician in the rheumatology section of medical services of the Pettis Memorial Veterans Hospital in Loma Linda. Dr Wong earned his medcial degree from Loma Linda University, where he completed his residency and internship training.

Mohamed H. Yafai, MD,* board-certified internal medicine specialist, has moved to the Mercy Walworth Medical Center. He comes from Milwaukee, where he held a full time faculty position at the University of Wisconsin Medical School, Milwaukee Clinical Campus at Sinai Samaritan Medical Center. He is a graduate of Long Island University in Brooklyn, NY, and Ross University School of Medicine. He completed his internship and residency at West Suburban Hospital Medical Center in Oak Park, Ill. ❖

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Wausau Regional Health Care, Inc.

County society news

Ashland-Bayfield-Iron. The Ashland-Bayfield-Iron County Medical Society approved membership for Lisa R. Capell, MD.

Chippewa. The Chippewa County Medical Society met at the Flame Restaurant on Oct 18, 1994. Dr Ben Wedro, ER physician from La Crosse, shared his experiences as a member of the CBS broadcast team for the winter olympics. Membership was approved for Paul W. Schaus, MD; and Arturo Sapida, MD.

Fond du Lac. The Fond du Lac County Medical Society met on Jan 26, 1995. Guest speaker was Mike Kirby, SMS Government Relations director. He discussed Legislative Bill #36, regarding a cap on noneconomic damages in malpractice suits, Medicaid reimbursement, and changes in practice for nurse practitioners and psychologists. Joseph Kennedy, DO, was accepted as a new member.

Green Lake-Waushara. New members accepted into the Green Lake-Waushara County Medical Society are David Kurtz, MD, and Steven A. Weber, DO.

Kenosha. The Kenosha County Medical Society approved membership for Bradley N. Haugstad, MD; Pervaz M. Choudry, MD; and Abdul Q. Arif, MD.

Lincoln. Ronald G. Cortte, MD, has been approved for membership in the Lincoln County Medical Society.

Manitowoc. The following physicians were approved for membership in the Manitowoc County Medical Society: Diane Staudinger, MD; Michael Randolph, DO; and Barton Siebring, MD.

Marathon. The Marathon County Medical Society approved membership for Hamied R. Rezazadeh, MD.

Marinette-Florence. The Marinette-Florence County Medical Society approved membership for John T. Hallfrisch, MD.

Outagamie. The Outagamie County Medical Society approved membership for Mark C. Austin, MD; Jack C. Anderson, MD; Sonya R. Eiben, MD; Michael A. Johnson, MD; Gail M. McNutt, MD; David R. LeCloux, MD; Stephen R. Dernlan, MD; John S. Toussaint, MD; Wendy J. Barton, MD; Taylor E. Marlowe, MD; and Steven J. Price, MD.

Pierce-St Croix. New members accepted into the Pierce-St Croix Medical Society include: Gregory T. Goblirsch, MD; and Timothy F. Steinmetz, MD.

Rock. The following physicians have been approved for membership in the Rock County Medical Society: Dolores M. Burant, MD; Randall K. Cullen, MD; Charles A. LaRoque, MD; Howard S. Paul, MD; Robin B. Stickney, MD; Carol Tomlinson, MD; James N. Warren, Jr, MD; George W. Wirtanen, MD; and Lawrence G. Wong, MD.

Vernon. The Vernon County Medical Society met in Viroqua on Feb 6, 1995, at Nate's Supper Club. The guest speaker was Dr Guy Fiocco, from the Guderson Clinic department of rheumatology. He discussed joint aspiration and injection in degenerative joint disease. Election of officers was held. Mark Heberlein, DO, was approved for membership.

Waukesha. The Waukesha County Medical Society approved membership for the following physicians: Al Baltrusaitis, DO, MPH; Thomas J. Gvora, MD; David S. Haskell, MD; Henry M. Kaminski, MD; Mark L. Leitschuh, MD; Michael J. Phillips, MD; Mark Siegel, MD; Robbin Papendick, DO; and Scott G. Zahn, MD.

Winnebago. The Winnebago County Medical Society approved membership for the following members: Reeta Thurkal, MD; Ilan Shapiro, MD; Steven Blaha, MD; Mark Hatton, MD; Pradeep Giriyappa, MD; Virginia Wilson; John Wilson, MD; Kristy Genners, MD; Rebecca Wolfe, MD; Elizabeth Schertz, MD; Thomas Zoch, MD; William Groves, MD; Megan Landauer, MD; and Julia Wilson, MD. ❖

Return to work form

During the last year, the SMS Commission on Environmental and Occupational Health revised the *Return to Work/Physical Capabilities Report* (Return to Work Form). Led by commission member Sridhar Vasudevan, MD, the form was revamped to make it more comprehensive, understandable, and user friendly for health care providers as well as patients and employers. Physicians, nurses in occupational health, and many others participated in the development and review of the new form. For information on how to purchase the *Return to Work* forms call Bill Guerten at 1-800-362-9080. The form can be found on the next page.❖

Date of Report: ____/____/____
Employee ID#: _____

RETURN TO WORK/PHYSICAL CAPABILITIES REPORT

Employee Name: _____ Date of Birth: ____/____/____

Employer Name: _____ Position: _____

Employer Address: _____ Date of Injury: ____/____/____

TO BE COMPLETED BY ATTENDING PHYSICIAN

Relevant Diagnosis: 1. _____
2. _____
3. _____

Condition: ☐ Improved ☐ Unchanged ☐ Stable ☐ Symptoms Worse ☐ NA **Work Related:** ☐ Yes ☐ No ☐ ?

WORK DEFINITIONS

Work level (lift/carry)		Per work shift	
Sedentary (Sed)	0 - 10 lbs.	Never (Nvr)	0%
Light	10 lbs. freq. - 20 lbs. max	Seldom	1 - 10%
Light - Medium	20 lbs. freq. - 35 lbs. max	Occasionally	11 - 30%
Medium (Med)	20 lbs. freq. - 50 lbs. max	Frequently	34 - 66%
Heavy	50 lbs. freq. - 100 lbs. max	Continually	67 - 100%

WORK AND OFF WORK CAPABILITIES

☐ Stitches/Butterflies ☐ Prescription Meds

☐ 1. Employee should be able to return to previous work without restrictions on ____/____/____.
☐ 2. Employee is totally disabled,
☐ 3. Employee should be able to return to work on ____/____/____ subject to following restrictions; until ____/____/____. ☐ Permanent
☐ 4. Medications prescribed may affect work performance.

Work level ☐ sed ☐ light ☐ light/med ☐ medium ☐ heavy
Hours/day _____
Days/week _____
Days overtime/week _____

May sit _____ hrs at a time
May walk _____ hrs at a time
May stand _____ hrs at a time
Should change positions every _____ hour/s
May only work between _____ and _____ levels
Not work more than _____ inches from body

May Bend:	☐		☐		☐		☐		☐														
Bend:	☐ Nvr	☐ Seldom	☐ Occas.	☐ Freq.	☐ Cont.																		
Squat:	☐ Nvr	☐ Seldom	☐ Occas.	☐ Freq.	☐ Cont.																		
Climb:	☐ Nvr	☐ Seldom	☐ Occas.	☐ Freq.	☐ Cont.																		
Crawl:	☐ Nvr	☐ Seldom	☐ Occas.	☐ Freq.	☐ Cont.																		
Twist:	☐ Nvr	☐ Seldom	☐ Occas.	☐ Freq.	☐ Cont.																		

***SPECIFY - RIGHT, LEFT or BILATERAL (Circle R-L-BIL)**

Grasp:	☐ Nvr	☐ Seldom	☐ Occas.	☐ Freq.	☐ Cont.	R - L - BIL
Pinch:	☐ Nvr	☐ Seldom	☐ Occas.	☐ Freq.	☐ Cont.	R - L - BIL
Twist (wrist):	☐ Nvr	☐ Seldom	☐ Occas.	☐ Freq.	☐ Cont.	R - L - BIL
Push/Pull wih hands	☐ Nvr	☐ Seldom	☐ Occas.	☐ Freq.	☐ Cont.	R - L - BIL
Fine finger manipulaton:	☐ Nvr	☐ Seldom	☐ Occas.	☐ Freq.	☐ Cont.	R - L - BIL
Wrist flextion/extension:	☐ Nvr	☐ Seldom	☐ Occas.	☐ Freq.	☐ Cont.	R - L - BIL
May use feet for repetitive movements:	☐ Nvr	☐ Seldom	☐ Occas.	☐ Freq.	☐ Cont.	R - L - BIL
Exposure to unprotected heights:	☐ Nvr	☐ Seldom	☐ Occas.	☐ Freq.	☐ Cont.	R - L - BIL
Exposure to moving machinery:	☐ Nvr	☐ Seldom	☐ Occas.	☐ Freq.	☐ Cont.	R - L - BIL

Boxes not marked indicate no restriction

I saw this patient on ____/____/____. Patient discharged: ☐ Yes ☐ No Patient to be seen again for re-evaluation on ____/____/____.
Other Comments/Recommendations: Referred to: _____

Physician's written signature: (no stamps) Date:

Physician's Printed or Stamped Name/Address/City/State: Phone:

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize my attending physician and/or hospital to release any information or copies thereof acquired in the course of my examination or treatment for the injury identified above to my employer or employer's representative.
Patient's Signature: Date: ____/____/____

*this is just a physician's estimate of the patient's ability to perform the task.

Obituaries

Bahr, Robert Dennis, MD, died Dec 18, 1994. He was born May 21, 1928. He received his medical degree in 1954 from George Washington University School of Medicine. He practiced radiology from 1967 to 1988 at West Allis Memorial Hospital. Dr Bahr is survived by his wife, Patricia; children, Leslie, Robin, Terri, and AlLison; one sister, one brother, and three grandchildren.

Duehr, Peter A., MD, died Dec 2, 1994. He graduated from Rush Medical College in 1929, specializing in ophthalmology. He served his internship and residency at Wisconsin General Hospital in Madison. He was associated with the Davis and Duehr Eye Clinic.

Farrell, Hubert James, MD, died Feb 8, 1995. Dr Farrell received his BS and MD degrees from Marquette University. He received a Masters of Science from the University of Minnesota and did his residency at Mayo Clinic. He was an instructor and associate professor of dermatology at Marquette Medical School for many years. He was a staff member at Milwaukee County, St Mary's Children's, Columbia, and Veteran's hospitals. He practiced dermatology in Milwaukee for more than 50 years. Dr Farrell was past president of the Wisconsin Dermatological Society, director for Venereal Disease Control as part of the US Public Health Service, and a member of the US Auxiliary Coast Guard during WWII. Dr Farrell is survived by five daughters, Margaret Smith, of Concord, NC, Jean Jermain and Mary Pat Kiehm, both of Glendale, and Kathleen O'Brien and Jane Krembs, both of Seattle, Wash; a brother; 21 grandchildren and 14 great-grandchildren.

Hardgrove, Maurice A., MD, died Feb 5, 1995. He received his medical degree from Columbia University Medical School. Dr Hardgrove specialized in internal medicine. He is survived by his wife, Olive, and a brother.

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.❖

JD Kabler, MD, died in late February at his home in Madison. He was born Dec 29, 1926, in Wichita, Kan. Described as "a giant in medicine," "the embodiment of dignity," and "the definition of character" by Madison physicians and long-time friends, Dr Kabler graced the lives of those around him with the lights of leadership, wisdom, and humor.

Dr Kabler was, until his retirement in 1992, a professor of medicine at the University of Wisconsin Medical School and director of the University Health Service. He served as president of the SMS in 1988-1989, president of the Dane County Medical Society in 1978-1979, president of the Madison Academy of Internal Medicine in 1984-1985 and as a delegate to the AMA since 1982.

Dr Kabler enlisted for active duty in 1944 and served in the US Naval Reserve until 1956. He was a member of the Wisconsin Army National Guard from 1956 to 1974, was appointed by Gov Knowles as chief surgeon (1967-1974), served as commander of the 13th Evacuation Hospital in 1966-1967 and as a member of the US Army Advisory Committee on Reserve Medical Affairs to the Surgeon General from 1969 to 1974. In 1974, Dr Kabler was decorated with the Legion of Merit.

Dr Kabler was president of the University Hospital's medical staff from 1979 to 1982, and a consulting physician to the Veteran's Administration Hospital. A certified specialist in internal medicine, Dr Kabler was known nationally for his work in the treatment of pain, particularly of headaches.

At the time of his death, Dr Kabler was chair of the SMS Commission on Medicine and Ethics, a member of the both the SMS delegation to the AMA and the *Wisconsin Medical Journal*'s Editorial Board and the nominee for the AMA Distinguished Service Award. He was formerly chair of the SMS Joint Practice Committee and Governmental Affairs Commission, as well as a member of the SMS Board of Directors and Task Force on Medical Manpower. He served as president of the North Central Medical Conference in 1989-1990, representing physicians in Wisconsin, Minnesota, Iowa, Nebraska, North Dakota and South Dakota.

Dr Kabler received his baccalaureate, with election to Phi Beta Kappa, and his medical degree, with election to Alpha Omega Alpha, from the University of Kansas. He

served an internship, residency and fellowship in internal medicine, with election to Sigma Xi, at the University of Wisconsin Hospital and Clinics.

An involved member of his community, Dr Kabler contributed as a board member for the Dane County Red Cross, medical advisor to the Visiting Nurse Service, project director for the "Blue Bus" Clinic in Madison, and president of the Wisconsin College Health Association. After his retirement and through an innovative project at the UW Medical School, in which physicians are mentors to students throughout their academic careers, Dr Kabler was a source of information and inspiration, and encouragement and enlightenment to scores of medical students.

He is survived by his wife Bea, five children and five grandchildren.

Requiem
Under the wide and starry sky
Dig the grave and let me lie.
Glad did I live and gladly die,
And I laid me down with a will.

This be the verse you grave for me:
Here he lies where he longed to be;
Home is the sailor, home from the sea,
And the hunter home from the hill.
--R.L. Stevenson

Pelkey, Ralph B., MD, died Feb 11, 1995. He received his medical degree from the UW Medical School, and interned at Milwaukee Hospital. He practiced in Coleman for three years, before moving his practice to Pound, Wis. Dr Pelkey is survived by his wife, Lorraine; three daughters, Patricia, Sue, and Moira; and one son, Ralph, Jr.

Rose, Robert John, MD, died Feb 3, 1995. He was born June 9, 1913, and graduated from Marquette University College of Medicine. He served his internship at Mercy Hospital in Gary, Ind, and took his residency at Tufts New England Hospital and Truesdale Hospital in Fall River, Mass. He served as major during WWII with the US Army Air Corps, Medical Service. He practiced medicine in Green Bay from 1946 to 1986. He was a member of the staffs of St Mary's, St Vincent's and Bellin hospitals. Dr Rose was a member of the AMA, SMS, and Brown County Medical Society. He is survived by his wife, Carol; his children, Robert J. Rose, MD, of Hanover, NH; Nancy Bultman, of Dallas; James Rose, of Sheboygan; Virginia Harney, of Fond du Lac; nine grandchildren and four great-grandchildren.

Scudamore, Harold H., MD, died Dec 15, 1994. He received his medical degree from Northwestern University Medical School in Chicago. He served an internship at Evanston Hospital. He attended the Mayo Graduate School of Medicine. He was appointed to the staff as a consultant in medicine in 1952, and became an instructor. He later joined the Monroe Clinic, and served as medical director. Dr Scudamore is survived by his wife, Virginia, and four children.

Sidhu, Narinder K., MD, died Dec 20, 1994. She was born April 13, 1955. She received her medical degree from the Government Medical School in Amritsar, Pumjab, India, and served her internship and residency at Children's Hospital in Milwaukee. Dr Sidhu was a pediatrician at Capitol Pediatric Care. She was a member of the SMS and Medical Society of Milwaukee County.❖

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FAX (608) 791-9898 or
Phone (608) 791-9844, Ext. 6329

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The cover letter must also designate one author as correspondent and provide a complete address and telephone number. All coauthors should have contributed to the study and manuscript preparation. They should be thoroughly familiar with the substance of the final manuscript and be able to defend its conclusions.

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All manuscripts will be edited by the *Journal* staff for clarity, organization, grammar, spelling, and punctuation, and in accordance with AMA style (AMA *Manual of Style*, 8th ed, and AMA *Manual for Authors and Editors*). Suggestions for titles are welcome, but are subject to the constraints of clarity, space, grammar and style.

The corresponding author will be asked to review a galley proof prior to publication to verify statements of fact. Galley proofs are for correcting errors; revisions should be made before submission, but must be made prior to final acceptance of the paper. The authors are responsible for all statements made in their work, including any changes made by the editors and authorized by the corresponding author.

Preparation of scientific manuscripts

- Submit papers to: *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701; Ph: 608-257-6781 or 1-800-362-9080; FAX: 608-283-5401.
- Authors are encouraged, whenever possible, to submit manuscripts on computer disks, using IBM-compatible software. Electronic submissions are also possible. A printed copy must accompany all disk and electronic submissions.
- Typed manuscripts must be submitted in triplicate (one original, two photocopies). Type on one side only of standard-sized white bond paper, using 1-inch margins. Double-space throughout.
- Organization for scientific papers:

Abstracts--150 words or less, stating the problem considered, methods, results and conclusions. Cite no references.

Methods--Describe the selection of observational or experimental subjects, including controls. Identify the methods, procedures and equipment well enough to allow replication.

Results--Provide results in the test, tables or illustrations. If tables or illustrations are used, emphasize or summarize only the most important observations in the text.

Discussion--Discuss the conclusions that follow from the results, as well as their limitations and relations to other studies. Show how the conclusions relate to the purpose of the study. Recommendations, when appropriate, may be included.

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- Avoid the use of medical jargon. Words or phrases that are particular to conversations among medical personnel are inappropriate in scientific writing. (Examples: For "presented with" use "had;" for "experienced a weight loss" use "lost weight.")
- Authors are responsible for supplying the full and correct names of drugs. Use generic names of drugs, unless the specific trade name of a drug is directly relevant to the discussion. If the author so desires, brand names may be inserted in parentheses.
- Units of measure are to be provided in metric, followed by International System units (SI) in parentheses.
- Provide each author's full name and highest academic degree in the byline. If an author holds two doc-

toral degrees (eg, MD and PhD, or MD and DDS), either or both may be used, according to the author's preference. Honorary American designations (eg FACP or FACS) are omitted. If the author holds a doctorate, master's and bachelor's degrees are omitted. Courtesy titles (eg, Mr, Mrs, Ms) are omitted from bylines and text.

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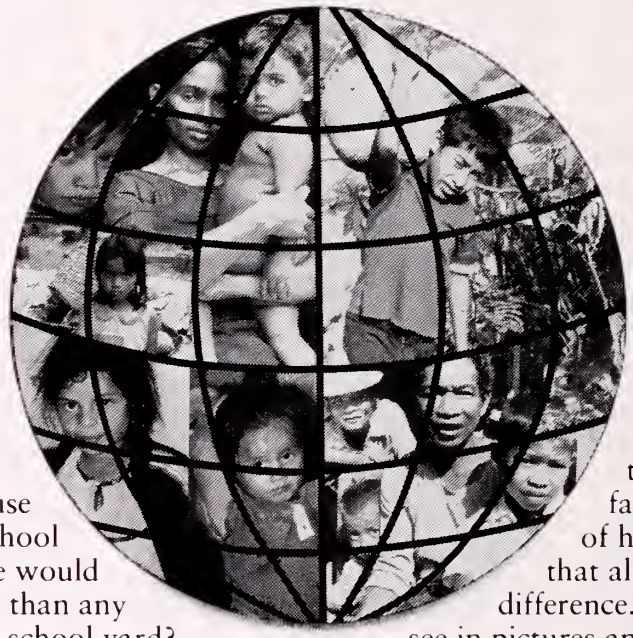

Look closely. Are these children any different than our children? If the boy on the right didn't look so tired from working in the fields and was smiling because he was able to start school today, do you think he would appear much different than any kid you might see in a school yard?

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Medical Director
Community Care for the Elderly
5228 W. Fond du Lac Avenue
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414-536-2110, ext. 254.

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SOUTHEAST WISCONSIN - Premier multispecialty group expanding Family Practice department. Call 1:6 with highly credentialed colleagues and strong referral network. Safe/clean lakefront community less than one hour from major metro. Excellent compensation and benefits package. For more information, call Stephen N. Barris, 1-800-765-3055, and mail/fax C.V. to: 314-726-3009, Cejka & Co., 222 S. Central Ave., Ste. 700, St. Louis, MO 63105. 3-8/95

BOARD CERTIFIED/ELIGIBLE FAMILY PHYSICIAN invited to join a rewarding and professionally stimulating ten physician practice at the Family Medical Clinic in Amery, Wisconsin. The Family Medical Clinic is adjoined to the newly renovated 36 bed Apple River Hospital and affiliated with Ramsey Clinic, a 215 multi-specialty group practice in nearby St. Paul, Minnesota. Physicians enjoy a private-like practice setting with immediate specialty consultations, vertically integrated care, research and teaching opportunities, and financial security. Lake sprinkled Amery is an ideal home for outdoor enthusiasts and yet in easy proximity to cultural activities in the Twin Cities of Minneapolis and St. Paul. Please contact Aynsley Smith at: St. Paul-Ramsey Medical Center, 640 Jackson Street, St. Paul, Minnesota 55101-2595 or (612) 221-4230. 3-5/95

PEDIATRICIAN - BC/BE to join Pediatric Associates in Milwaukee, St. Joseph/Sherman Park community. Competitive salary, generous fringe benefits. Reply to Malke, c/o Pediatric Associates, 4267 W. Fond du Lac Avenue, Milwaukee, WI 53216. 1-6/95

FAMILY PRACTICE POSITION - Northern Illinois - Winnebago. Family practice physician needed for patients in the Winnebago, Pecatonica, and Durand area at a new clinic in this developing area. This area is designated as an Illinois underserved area for physicians with IDPH loan repayment commitments, but not for federal. As part of OSF Healthcare and Saint Anthony Medical Center in Rockford, this position is a full time salaried position with comprehensive benefits, including CME, vacation, pension plan, and insurance. Board prepared or certified family practice physician with excellent interpersonal and communication skills is a must. Call is 1 in 4. For more consideration: contact Marie Noeth at 800-438-3745 or fax CV to 309-685-1997. OSF Healthcare, Member NAPR. 3/95

NO ASSEMBLY LINES HERE. FPs, IMs and OB/GYNs at North Memorial owned and affiliated clinics don't hand patients off to the next available specialist. Guide your patients through their entire care process at one of the 25 practices in urban or semi-rural Minneapolis locations. Plus, become eligible for $15,000 on start date. Interested BC/BE MDs, call 1-800-275-4790 or fax CV to 612-520-1564. 1,3,5,7,9,11/95

PRIMARY CARE PHYSICIANS AND SUBSPECIALISTS are being sought for a variety of group practices located throughout the upper Midwest and New York State. Choose from metropolitan cities, college towns, popular resort communities or traditional rural destinations. This month, opportunities available for physicians specializing in family practice, internal medicine, pediatrics, occupational medicine, hematology/oncology and nephrology. New opportunities monthly! For all the facts, call (800)243-4353 or write to: Strelcheck and Associates, 10624 North Port Washington Road, Mequon, WI 53092. 1-3/95

FAMILY PRACTICE physician needed by progressive and growing group prac-

St. Croix Falls, Wisconsin

Community of 2000 seeks additional Family Practitioner. Practice consists of 13 Family Practitioners, 2 Internists, 2 General Surgeons and 1 Orthopedic Surgeon. Many specialists available on a part-time basis. We are attached to a 90-bed hospital with comprehensive service available. We have a stable medical group with pleasant working conditions in a continuous growth mode.

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Cathy Kortas
River Valley Medical Center
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(715) 483-3221.

3-5/95

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Physicians Exchange

Continued

tice in west central Wisconsin. City of 60,000. Ninety miles from Minneapolis/St. Paul. Primarily prepaid practice with large component FFS. Highly competitive salary with excellent fringe benefits. Practice quality care in good recreational area. Send CV to James A. Volk, MD, Medical Director, PO Box 3217, Eau Claire, WI 54702-3217; ph 715-836-8552. 2-7/95

INTERNAL MEDICINE AND PRIMARY CARE - WISCONSIN. Excellent opportunity in beautiful Milwaukee suburb at well established small multispecialty clinic. Full partnership after one year. Send CV to Ozaukee Medical Center, 407 N. Main Street, Thiensville, Wisconsin 53092. 1-3/95

TOMAH. Ambulatory Care. Tomah VA Medical Center seeks a BC/BE family practitioner or general internist with a strong interest in Ambulatory Care/Primary Care to join our staff. Responsibilities include direct patient care. Excellent benefit package includes malpractice protection, 30 days paid vacation, and annuity plan. Relocation expenses. 173-acre facility includes limited on-station housing. City of 8,000 in a predominantly rural area that offers affordable real estate, good schools. Conveniently located on I-90/94 midway between Milwaukee and Minneapolis. Interested candidates should contact the Associate Chief of Staff for Ambulatory Care (11F), (608) 372-1785, VA Medical Center, 500 East Veterans Street, Tomah, Wisconsin 54660. AA/EOE. 1-4/95

JANESVILLE, WISCONSIN, DEAN MEDICAL CENTER, a 300 physician multispecialty group, is actively recruiting additional BE/BC internal medicine physicians to practice at the Riverview Clinic locations in Janesville, Milton and Delavan, Wisconsin. Traditional internal medicine and urgent care practice opportunities are available. Janesville, population 55,000, is a beautiful, family oriented community with excellent schools and abundant recreational activities. Excellent compensation and benefits are provided with employment leading to shareholder status. Send CV to Stan Gruhn, MD, Riverview Clinic, PO Box 551, Janesville, WI 53547 or call (608)755-3500. 1-3/95

JANESVILLE, WISCONSIN, URGENT CARE: Riverview Clinic, a division of Dean Medical Center, is actively recruiting an urgent care physician to join its medical staff. We recently increased our compensation package which is based on a 40 hour work week. Total compensation for Year 1 - $108,000.00, Year 2 - $134,642.00 and Year 3 - $135,000.00. We currently have two physicians which staff the clinic from 9:00 AM - 9:00 PM, Monday through Friday and 9:00 AM - 11:30

La Crosse, Wisconsin

BC/BE general pediatrician to join four pediatricians in growing multispecialty (70 physicians) group. Competitive guaranteed income/benefits. Affiliation with local hospital system and major medical center expected. Desirable midwestern, small city in beautiful Mississippi River Valley. Great family atmosphere, excellent schools and recreation opportunities.

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3-5/95

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Requirements include Board Certification in internal medicine or family practice, eligibility for state licensure, and at least 2 years of medical practice experience. Service on a hospital peer review, utilization review, quality assurance committee, or as a Medical Director of an HMO is essential.

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Physicians Exchange

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AM on Saturday and desire to expand the hours of operation until 9:00 PM on Saturday and 1:00 PM - 9:00 PM on Sunday. Our facility is brand new and well equipped with 8 exam rooms, lab and x-ray. Flexible hours are available with an expected total of 30-40 hours per week. Excellent compensation and benefits are provided. For more information contact Scott M. Lindblom, Dean Medical Center, 1808 West Beltline Highway, Madison, WI 53713,(work phone) 1-800-279-9966 or (608)259-5151, FAX (608)259-5294, (home phone) (608)833-7985. 1-3/95

MADISON, WISCONSIN, DEAN MEDICAL CENTER, a 300 physician multispecialty group is seeking additional family physicians to join its 30 member department. Positions are located at our Arcand Park, East Madison and Deerfield Clinic locations. All positions have an excellent call schedule and obstetrics is optional. Madison is the home of the University of Wisconsin with enrollment of over 40,000 students and the state capital. Abundant cultural and recreational opportunities are available year round. Excellent compensation and benefits are provided with employment leading to shareholder status. Fore more information contact Scott M. Lindblom, Dean Business Office, 1808 West Beltline Hwy., P.O. Box 9328, Madison, Wisconsin, 53715-0328, work at 1-800-279-9966, (608)259-5151 or at home (608)833-7985. 1-3/95

NATIONWIDE - Opportunities for the following: IM, FP, OB/GYN, PED, ONC, CD, and more. Send CV to Stan Kent, Stan Kent & Associates, P.O. Box 904, Tremont, IL 61568, or call 800-831-5679, FAX 309-925-5842. 1-5/95

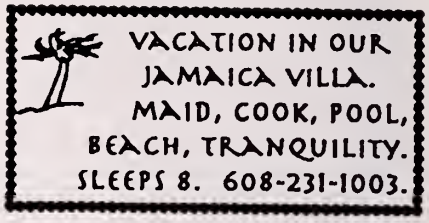
INTERNAL MEDICINE, CARROLL, IOWA - Outstanding professional opportunity for an internal medicine physician in a progressive, safe and clean community of 10,000 located in west central Iowa, 90 miles from Des Moines, Iowa or Omaha, Nebraska. This opportunity is available for either an in practice internal medicine physician, or the internal medicine physician just beginning practice. Excellent schools (Catholic and public), quality hospital featuring a radiation oncology center, dialysis center, and a new 32,000 sq. ft. outpatient addition. Significant income potential available. For more information, call Randy Simmons, Vice President, at 1-800-382-4197 or write St. Anthony Regional Hospital, South Clark Street, Carroll, IA 51401. 11/94-4/95

MILWAUKEE AREA. A rapidly expanding 70 physician multi-specialty clinic seeks BC/BE physicians in the following specialties: family practice, internal medicine, urology, oncology, pediatrics, general surgery and OB/GYN. Competitive salary, excellent fringe benefits. Address inquiries and CV to: Medical Associates Administrator, PO Box 427, Menomonee Falls, WI 53052-0427. 11/94-4/95

WISCONSIN: Family practitioner-Internal medicine needed by a growing practice of a four physician group in a friendly rural community in Northeast Wisconsin near Green Bay. This is an excellent opportunity to join an established organization. Highly competitive salary with benefits. Please contact: Artwich Clinic, Oconto Falls, Wisconsin 54154. 9/94-5/95

THE WAUSAU MEDICAL CENTER is seeking Board Certified-Eligible individuals in the following specialties: Internal Medicine, Family Medicine, Obstetrics/Gynecology, Occupational Medicine and Urology. Large multispecialty group located in central Wisconsin. Competitive salary (incentive after first year). Comprehensive benefit package including malpractice insurance, flexible benefit plan and profit sharing. Modern facility located directly across the street from 250-bed acute care facility. The area is ideal for outdoor enthusiasts (including large downhill ski area) with outstanding cultural activities year round. Write or call collect David K. Aughenbaugh, MD, Medical Director, Wausau Medical Center, 2727 Plaza Drive, Wausau, Wisconsin 54401, telephone (715) 847-3235. 2/93;TFN

Miscellaneous



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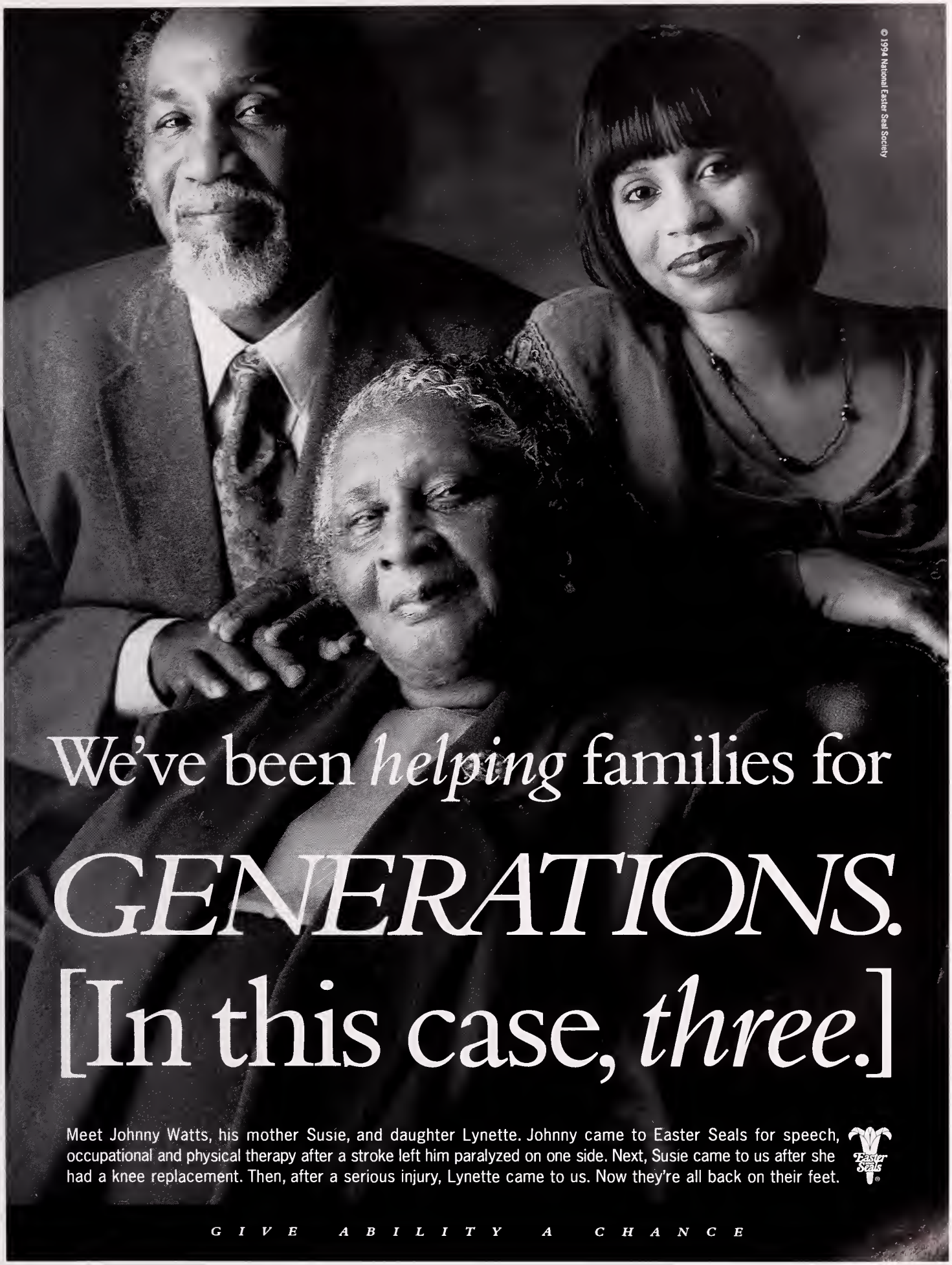
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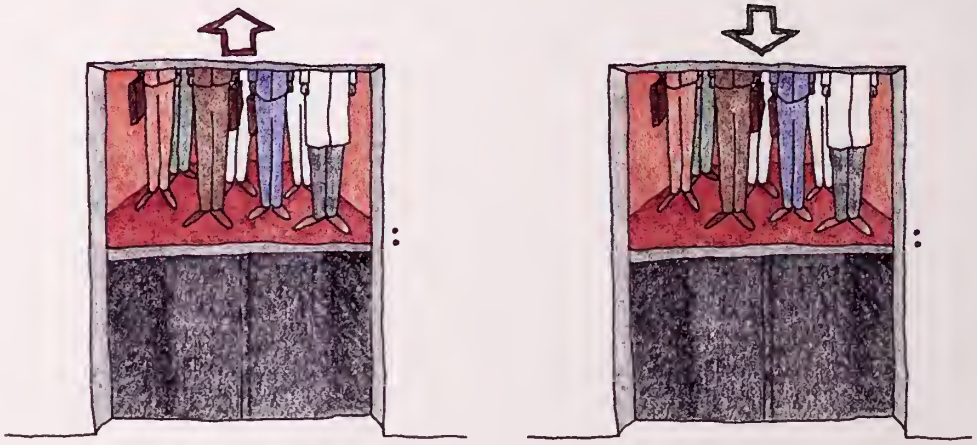

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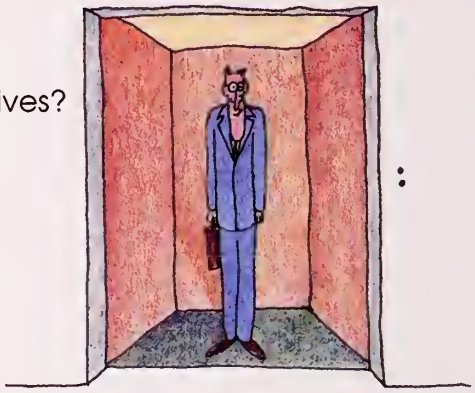

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Created by the Territorial Legislature in 1841 and now representing nearly 8,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal*.

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Our cover: "Color fundus photograph of the left eye of a patient with insulin dependent diabetes showing fine new vessels on the optic nerve head. The visual acuity is excellent, 20/15 and the patient is asymptomatic. If left untreated with panretinal photocoagulation, there is 50% risk of severe loss of vision to 5/200 or worse in this eye." You'll find related articles on pages 197 and 213.

If the U.S. Senate Can Deliver Health Care Liability Reform, Maureen O'Regan Can Deliver Babies Anywhere.

Meet Dr. Maureen O'Regan.

She's an obstetrician in northern Virginia, within sight of the nation's Capitol.

She delivers babies in Virginia where there's a limit on health care liability awards.

Just across the Potomac River, in Washington, D.C., there is no limit, and malpractice insurance costs at least $68,000 – more than twice the cost in Virginia.

Dr. O'Regan would like to deliver babies in Washington, but the cost is too high and the risk is too great.

She's not alone. One out of eight obstetrician/ gynecologists nationally no longer delivers babies. Other doctors all across the country struggle with the same dilemma.

Without liability caps, huge amounts of money are spent on defensive medicine. Physicians must order more procedures and tests than the patient really needs. The trust between patient and physician is threatened.

Congress can fix this. The U.S. House of Representatives has already passed a bill that would set a $250,000 cap on noneconomic damages. Now it's up to the U.S. Senate.

Contact your U.S. Senators **now**. Tell them to vote for Health Care Liability Reform.

And let Dr. O'Regan deliver babies wherever she's needed.

*Write **both** U.S. Senators c/o U.S. Senate, Washington, D.C. 20510. Or call their offices at (202) 224-3121.*

American Medical Association

Physicians dedicated to the health of America

President's page

Your future is what you choose to make of it

As President of the State Medical Society, you spend a lot of time in small twin engine planes going from place to place. Sometimes the parade of places can blur one into the other. Etched in my memory however, is a flight last fall that began in clear skies just before dusk. Heading northwest, the horizon took on a lavender pink glow as we chased a sinking orange sun. After an hour, we could see up ahead a curtain of thick cumulus clouds that had rolled in off Lake Superior. Draped over Ashland, our destination, the clouds loomed before us like an ominous netherworld we were about to enter.

On descent, our colorful panorama suddenly gave way to a smothering gray white as the clouds swallowed us. Sinking, sinking, sinking, it felt like we were falling down a smoke-filled stack. My gaze was glued to the altimeter as we dropped: 3000, 2000, 1000 feet.

At such times, I invariably torture myself with mental images of radio towers and ski hills exploding suddenly out of the smokiness. We finally punched out of the droning gray at 700 feet into a hazy darkness with the shimmering lights of Ashland below. With winds gusting to 30 knots, I came to know the challenge of pitch and yaw to sphincter control as we bumped and wiggled our way to touchdown.

Later that night, on the ride back to the airport, I reflected on a most pleasant evening with the good doctors of Ashland and I decided that the trip had been well worth the effort. A too-warm car and a full meal distracted me into a drowsy drifting as I mentally charted the journey home. Then I remembered that gray blanket heavy overhead. I sat straight up and my thoughts sharpened into focus.

Richard G. Roberts, MD, JD

Torn unexpectedly between rising anxiety and excited anticipation, I began to silently calculate drive times and reasons why we shouldn't fly. Nope, I concluded after accounting for comfort, convenience, and crash risk , flying was the only sensible way home.

Well, the return was not as dramatic as the arrival. The gray blanket was just as thick, but the reassur-

Continued on next page

Continued from preceding page
ing wing lights and the comforting certainty of clear sky overhead, somewhere, made the traverse much quicker the second time.

And then something magic happened. The pilot and I broke off our constant chatter and said nothing as we cleared suddenly at 7000 feet to a dream scene: below was a fluffy cotton carpet that was sidelit ivory by a brilliant white white moon off to our left that was huge. Studded across the blackness of the western sky were the stars as clear as I could ever remember them. The console lights were dim and the cabin was quiet.

We glided silently in the soft reflectance for almost an hour until Madison tower crackled an interruption. The pilot snapped to attention and busied himself with the controls and tower talk that would keep him occupied the rest of the trip. I was left to think about the clouds and clarity; fantasies and the future.

Ralph Waldo Emerson wrote, "This time, like every time, is a good one if we know what to do with it." It can seem like a struggle to know what to do. To know whether to plunge into the clouds or, if we're already in them, to know which direction will lead us back into clear skies. If we could just know the future. Well, we can see our future. It's reflected in the faces of our children and in the prophecies of our leaders.

We are all leaders at times and followers at times. Some of us grab for leadership when we shouldn't; others run from leadership as if they couldn't. The first becomes the tyrant, the second becomes the timid. To the first I say, "You think you've got power? Try ordering somebody else's dog around." To the second who questions, "What me lead? I can't even lead in silent prayer," I say to that person: destiny is choice, not chance. Your future is what you choose to make of it.

There are some who despair that America, and perhaps American medicine, has become a self-centered, special interest Tower of Babel. We must not give in to this sickness of the soul called despair. Like many ailments, this sickness is due to a deficiency, a deficiency of hope. I've travelled all over Wisconsin, I've visited with a lot of young people and a lot of physicians while sharing the message of CHILD SAFE, and I've looked into the faces reflecting our future...and I see hope.

My hope for Wisconsin medicine is that we will resist the temptation to wallow and whine and instead get on with the helping and the healing for which there has never been a better time to be a physician, a prescriber of hope. My hope is that we will continue to answer the call and help lead our communities to a better future.

Will Rogers once said, "We can't all be heroes because somebody has to sit on the curb and clap as they go by." My time at the head of this grand parade of heroes has come to a close. I'm looking forward to joining my family at a spot I've picked out on the curb. Thanks for letting me walk with you awhile.❖

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EVP report: The view from here
The SMS on the Marshfield Clinic case

After much discussion, some of it heated, Wisconsin physicians serving in the SMS House of Delegates overwhelmingly found a course on which they could agree regarding the filing of a friend of the court or amicus brief in the Blue Cross/Blue Shield v Marshfield Clinic case. The Marshfield Clinic plans to appeal a verdict which found the clinic guilty of violating antitrust laws by fixing prices, forcing independent physicians from its service area and excluding competing HMOs from the market. The Marshfield case has gained national interest and has the potential to become a landmark decision in determining precedents governing the delivery of health care. It is critical that the SMS members understand the basis for this action and the purpose of our amicus brief.

The brief to be filed jointly by the SMS and the AMA will not speak to the specific details of the Marshfield Clinic case, but will express support for the concept of physician-organized networks. The court brief will be based on the following principles:

The expansion of integrated networks of health care providers and group practices into sparsely populated areas holds the potential to improve access to high quality care, and should not be discouraged.

The expansion of health care providers into health care financing, such as an HMO, holds the promise of offering consumers more choices than non-provider controlled insurers can offer. A health care financing product should not be disadvantaged simply because it is owned by physicians practicing in the market.

All physicians including those in group practices, who have built a reputation for high quality services should be allowed to negotiate contracts with payers that compensate the providers for the reasonable value of those services.

The antitrust laws, which are important in furthering the interests of consumers in choosing among different forms of health care financing, can chill the very competition they are designed to encourage when used in an undisciplined manner. An antitrust plaintiff should have to clearly identify how a defendant's particular conduct in a particular market, resulted in antitrust damages to the plaintiff.

Antitrust damages must take into account quality of care in the particular circumstances. Crude measures of damages potentially chill investments in quality by providers in sparsely populated areas, where, of necessity, the provider may have a large market share in some physician services market. Consumers in rural areas may welcome, and be willing to pay for, such quality and access.

The case, of course, has other implications--involving the facts of the case--for the physicians at Marshfield, but the issues outlined here are those that carry significance for all physicians, in Wisconsin and across the nation. SMS participation in this brief allows Wisconsin physicians to avail themselves of a rare opportunity to assist the courts in the development of the antitrust laws. It is these broader issues which we will address in an effort to help the courts reach a decision that will preserve a greater share of economic freedom for physicians and enhance physician attempts to shape their own professional environments. It is these broader issues that the vast majority of SMS members can agree upon and work on together for their and their patients' common good.❖

Thomas L. Adams, CAE

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

Editorials are signed by the authors. These opinions are the authors' and do not necessarily reflect the policies of the SMS. Authorship of editorials is reserved for members of the *WMJ* editorial board, editorial associates and SMS elected officials.

Letters are signed by the authors. These opinions are the authors' and do not necessarily reflect the policies of the SMS. Authorship of letters is open to the public, but letters are limited to 500 words and subject to review by the *WMJ* editorial board. Write to: *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701.❖

Editorial
So long, it's been good to know you

I RECEIVED A TELEPHONE CALL on the 6th of April from a rather apologetic officer of the SMS, telling me that I would not be reappointed as medical editor of the *WMJ* because of the foofaraw created by my editorial "Arrogant faculty." It seems that, once again, I am paying the price for not stepping back from a position I knew was correct, even though it proved to be quite unpopular. The price paid is really not so high as one might imagine. I have served the *WMJ* for 18 years, and it is indeed time for new blood.

I did find it somewhat amusing that my dismissal was prompted by the supposedly urbane, intelligent, sophisticated physicians who found my position so unsettling. Rather than considering that there might be some truth in my editorial, these individuals immediately suggested it was greatly misinformed, which seems to be the universal rebuttal of the self-righteous and small minded--a rebuttal usually born of ignorance and always displaying gasconism and egocentrism in its highest form. I have had the privilege of dealing with such in the past.

When I first joined the editorial board, I was informed that neither of the medical schools or the Milwaukee Medical Society paid very much attention to the *WMJ* and almost never submitted manuscripts. The feeling at that time was that it was seldom read by the self-anointed elite physicians of the state. It would seem that I have again solved a couple of problems--which puts me in mind of a true story:

George and I occupied stools in the local tavern after work upon occasion. George worked for a door manufacturing company for 25 years, but people at the company did not know who he was. On one occasion, I stopped in for a brew, sat down next to George and said, "So how are things?" He said, "You know it's a funny thing, today I cut

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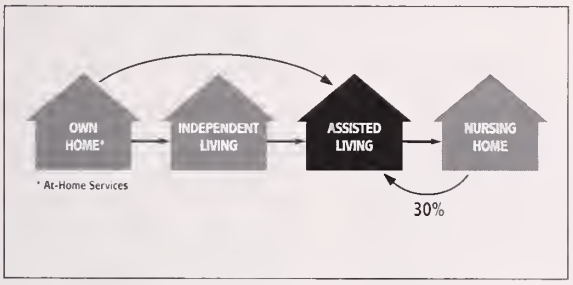

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a whole box of doors 3/4 of an inch short and now everybody knows who I am."

Having said that, however, I will hasten to say that I have greatly enjoyed my association with the WMJ and, most especially, with the officers of the "mother house" in Madison. My association with all of the editorial staff has been very, very rewarding, particularly my association with Russell King. I also have had many rich, warm experiences with the members of the editorial board. There are two of which I especially remember: Dr Melvin Huth and Dr J D Kabler. The association with these gentlemen was worth the price of admission. I greatly respected them, and it was very seldom that I did not take their advice.

I wish the new editor and the editorial board the best and hope they enjoy their tenure as much as I did mine. Actually, leaving office in this fashion certainly beats just fading away.

--Richard D. Sautter, MD
Marshfield ❖

Letters

The physician's role in assisting patients to end life

To the editor: Polls reveal that a majority of people believe that patients should have more control in end-of-life decisions, even asking assistance to end life under certain circumstances. Some have questioned why physicians' organizations should be opposed to such freedoms. Physicians have been leaders in advocating the right of a patient to know and to enter into decision making. Has this been just lip service? Could it be that complicated technology has been increasing a gap between the dominant authority and the dependent patient, giving less attention to patients' requests?

As the end-of-life debate increases, it is hoped that physicians will be involved but that pro and con positions will be offered with respect and without fractiousness. It is an absolute that no physician ever is required to be involved in anything considered personally to be immoral or unethical. Further, it is an absolute that any assistance in helping a patient to end life would be only by patient request. Many physicians are guided by Hippocratic and/or religious convictions. Arguments regarding the degree of such devotion to principles are specious and stray from the focus of discussion--how physicians can best help patients.

In medicine, we have prided ourselves on the individualization of our diagnosis and treatment recommendations. In that light, can we rule out that there are some patients who really need more assistance than we are giving them? Yes, Hospice, pastoral ministry, and aggressive pain management services are helpful and appreciated. Yet, there is abundant evidence that there are yet patients who have uncontrolled agonizing, painful courses when there is nothing left but to die.

Most people who are asking for assistance in ending life have never been suicidal as they lived out their lives up to the terminal state. In all the discussion about suicide, we have forgotten the precious word treatment, which may be what a patient wishes from somebody the patient trusts.

Legislators, even physicians, have used the "don't play God" defense, which is questionable, considering the countless number of decisions we make which affect patients' lives. Perhaps the height of "playing God" is to inform a patient that recovery is not possible, that death is a certainty--and then to require the patient to endure a societal-mandated course, unwanted and on somebody else's terms. Life, in a spiritual sense, cannot be defined in a narrow biological sense. In medical training, I am unaware of any narrow directive simply to preserve life. Our mission has been to listen, to treat, to comfort, to relieve--which usually preserves life. However, when mere preservation poses extreme hardship on a patient and family, then I wonder if we're being faithful to our calling. Somehow, for the healer to tell the family, "It shouldn't be long" seems hollow and without hope.

—Ralph F. Hudson, MD
Eau Claire

Editor's note: This letter is reprinted from the February *WMJ*. The original publication contained several production errors.❖

Editorial draws more fire

To the editor: It is with great sadness that I request you ask the immediate resignation of Dr Sautter as editor of the *Wisconsin Medical Society Journal* and any member of the editorial board who was aware and approved his editorial in the January issue. This editorial is not evidence based, distorts the truth and misinformed the readers. Above all, it is insulting, divisive, irresponsible and unjustified.

In his arrogance Dr Sautter, without providing any evidence accuses the UW Medical faculty and "the foreign nationals" of avarice and questions their integrity, their ethics and, in away painfully reminiscent of the McCarthy era, also questions their patriotism. Interestingly, the editorial board includes respected "foreign nationals" and university faculty.

It would also be appropriate for you and the leaders of the Wisconsin Medical Society to publish in the Journal an apology to the dedicated and respected "foreign nationals" for this unjustified insult, the actions taken by the Society to avoid such editorials in the future and that the resignation of Dr Sautter as editor has been accepted. If actions such as I proposed are not taken a massive resignation from the society may occur.

I am sure you would agree, that is not only sad but despicable and abhorrent to feel that McCarthysm and Nazism still around us, very close to us in the medical profession. Fortunately, I know and work locally and nationally with professionals that are not like Dr Sautter, I am in editorial boards of journals where such an editorial would have not been published as written and I am proud to belong to other societies where discrimination of any sort is unacceptable and sanctionable, where all humans are respected, but I am ashamed and not proud to know that in Wisconsin we have colleagues like Dr Sautter.

I hope that you and the leadership of the society will be able to redeem the society from this shameful event.

—Guillermo A. do Pico, MD
Madison❖

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There is nothing to negotiate

To the editor: I write to denounce Dr Sautter for his outrageous editorial in your January issue and the abuse of our journal to vilify foreign medical graduates.

Involved in a struggle at the medical school, he took sides expressing his feelings about it. There is nothing wrong with that. Yet, without any excuse or the ability to foresee the consequences of his manipulations, he selects "foreign nationals" as the target of this appalling diatribe. He links "those who may not put the medical needs of US citizens very high on their priority list," with "greed," the "deterioration of the public image of the profession," questionable "personal and professional ethics," no "sense of justice" or "patriotism," in a style painfully reminiscent of McCarthy's times. And all this because a "foreign national" was one among many colleagues on the "opposite team." Methodically he avoids mentioning FMGs which would include many US-born physicians. The stigma is being foreign. Instead of limiting himself to academic issues he incites the mob towards a pseudo-intellectual lynching of those "foreigners."

For generations, foreign doctors have been shoulder-to-shoulder with all Americans in the struggle for a better life without letting racial, cultural or economic characteristics prejudice our behavior. All over the country we serve rich and poor "taxpayers" and dispossessed, citizens and foreign nationals. We neither select nor reject them because of ancestry or passport.

There is no room here for excuses, hand washings, or good ol' boy networks. Alarming enough is the silence of those expected to review the editorial and the many who saw nothing wrong when reading it. The credibility of the society is at stake. There is nothing to negotiate. We demand an apology and his removal from any position of leadership in our journal and our society. His action has inflicted serious damage to both. This is professional cannibalism at its worst, just when we need unity more than ever before. Increasingly cornered by economic and political interests, the least stupidity tolerable is gang-war mentality within our ranks. We FMGs have the experience, the motivation and the capability to be at the front of efforts to protect the interests of our profession and to provide adequate health care to all the people. But not in those terms. If the society ignores us, we'll interpret this as approval of this inexcusable assault. Perhaps we should reconsider the reasons for our membership. We would prefer to make the public aware of this incident, depending on the outcome of our demands. Divisive? No more than this fiasco already is.

The society needs a frank self-examination of this subject. Except for the "Native Americans," all of us are or come from "foreign nationals." There is no place for bigots, racists, or xenophobes in a profession which must be universal in purpose. Its incredible that a physician, of all human beings, still has room in his brain for this medieval way of seeing others. We foreign medical graduates are either members on equal terms, or we aren't.

—Jose Miguel Moreno, MD
Milwaukee❖

Misinformed? Mean spirited?

To the editor: Since publication of my editorial titled "Arrogant faculty," there have been a number of responses, some supportive, some most decidedly not. What follows is a letter from Dean Marton, the subject of my original remarks:

Dear Dr Sautter: Your editorial in the *Wisconsin Medical Journal* was just brought to my attention and I thank you for it. It is the first, and only, public expression of support for what I tried to accomplish at UW. While I have some personal healing to accomplish, the damage inflicted on the health sciences at UW is of greater concern. I can only hope that rational thinking will once again prevail and that forward motion will resume.

I should clarify that while there was internal discomfort with the significant changes that we were trying to accomplish, there were really only a small number of self-interested individuals who considered their own well being above that of the medical school. Unfortunately, many others stood by watching passively. Had it not been for a fundamental decision on campus not to allow the health sciences to assume a leadership position, most of the faculty would have ended up as willing partners. Once again, the decision of a very few ruled.

I was impressed with your directness and honesty the very first time I met you, shortly after moving to

Continued on page 194

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Continued from page 192
Wisconsin. I am sorry that I was not able to meet and work with more individuals such as you.

Another physician wrote:
"I had numerous occasions to be involved with Dean Marton and also have learned things about his 'resignation' (resign by a certain date or you are fired) that makes me even more upset with the whole episode. He criss-crossed the United States meeting with alumni (who had not had anyone from Madison visit them in 30 years), outlining his plans and almost without exception everyone who heard him was ready to climb aboard the bandwagon and get his plan going, and many made significant contributions and pledges of money. Support was universal ... except for some big names on the faculty of the school who saw it as a threat to their well-established fiefdoms. Thus it would appear that a new permanent dean will be appointed from within the school, so that the downward rush to mediocrity can proceed unhindered."

You, the reader, will need to decide whether "I got it wrong" as suggested by the letters of Dr Richard Roberts and others in this and the previous *WMJ*. I will also leave it to you to decide whether my editorial was mean spirited. I can assure you, however, that it was not meant to be. I have genuine concerns for the medical school and for Wisconsin, and I shared them in an open forum designed for this purpose.

Perhaps I painted the faculty of the medical school with too wide a brush, but are those who were "watching passively" in the group of good men who allow evil to prevail by doing nothing?

If there was no conspiracy, why was the crucial vote taken when Dean Marton was out of town due to a religious holiday?

I apologize if I have offended any of the foreign nationals on the University of Wisconsin faculty. I have no axe to grind with them, so long as their first priority is the betterment of the medical school. I also apologize to those physicians practicing elsewhere in Wisconsin who read a paragraph of my editorial as an insult to all foreign-born physicians. I offered a description of what transpired and a suggestion of how it happened, not a blanket indictment of any group except the medical faculty. I deeply regret that it was taken otherwise.

(As an aside: The *WMJ* proudly keeps its opinion pages open to all viewpoints and does not subject editorials or letters to censorship by the Editorial Board, SMS Board of Directors or officers, or SMS staff. A reminder of this policy is published in each edition. My signed editorial was my personal opinion, and those who call for the dismissal or resignation of those who "allowed" me to express my opinion demonstrate either an ignorance of or a disdain for the sanctity and power of the First Amendment rights we all enjoy.)

Upon reflection, the problem at the UW Medical School appears to exceed just primary care and extends to the faculty practice plan and who is really in charge of the medical school. It would be quite interesting to determine the faculty dedication to teaching in those clinical departments where the chair's salary can exceed a half million dollars. One could, recognizing these enormous salaries, question whether the students are getting the teaching for which the state has paid. I am certain that a complete explanation of the faculty practice plan to Wisconsin taxpayers would be very welcome and astonishing to quite a few.

Some, perhaps many, of the faculty are told research is the No. 1 priority. This, of course, is admirable and certainly one of the priorities of the medical school. But aren't the taxpayers paying faculty to teach? The real question is who among faculty and faculty chairs consider and treat teaching as the No. 1 priority?

There is a person on the faculty for whom I have great respect: His honesty is never questioned. He indicated in his opinion that the dean was in complete control of the medical school. If that is indeed true, how was the "boss" fired? Is it possible that not all the faculty understand the power structure of the medical school and, therefore, can not recognize the present problem? Dr Roberts made reference to Chancellor David Ward's decision to fire him because of differences in "leadership and administrative styles." I believe that these are words used to disguise the fact that Dean Marton actually wanted to re-order and change things to help the UW Medical School enter this century.

Because of the magnitude of the problems facing the medical school, the Regents should investigate the situation, which is obviously out of control.

Perhaps a more direct route would be for Governor Thompson to appoint a committee to search out the problems and offer solutions. Say, hey, Tommy, I'd be glad to chair such a committee.

--Richard D. Sautter, MD
Marshfield❖

Kudos to SMS

To the editor: Congratulations to the State Medical Society for winning the MCH Achievement Award. The fact that 10,000 trigger locks have been distributed is great evidence of your success. Thank you for your leadership in heightening awareness about gun safety and violence prevention in Wisconsin.

—Richard A. Aronson, MD
Madison❖

More tributes to J D Kabler, MD

The following comments were offered at a memorial service for J D Kabler, MD, in Madison on March 7, 1995.

DEAR FRIENDS: Just a few days ago JD Kabler died suddenly and unexpectedly. All of us are in a state of disbelief and shock as we contemplate the loss. However, none of us feels more keenly and deeply this loss than his partner, Bea and their children. All of us extend a hand of comfort and sympathy to them in this hour of sadness and reflection.

JD was a well known physician in our state and is known to most of you. However, some may not know the outlines of his life. I will touch on some of the highlights. He was born in Wichita, Kansas. He was an only child. His father did clinical laboratory work for practicing physicians. Thus, early in his life he was in touch with health care.

He was an outstanding scholar early in life. He earned state-wide recognition in high school. He attended Tulane University in New Orleans as a V-12 student. This was a WWII program for pre-medical students. The war ended and he transferred to Kansas University at Lawrence. After completing the Baccalaureate degree there, he entered Kansas University Medical School in Kansas City. He finished his MD degree work there and started an internship at Wisconsin General.

He and Bea met in Kansas - she a nursing student, he a medical student. They married about the time he started his internship. They had five children, all of whom are here today.

He started his training in internal medicine here in Madison but it was interrupted by the Korean War. He went off to the Navy as a medical officer for two years. These 2 years were very influential in his later life. He developed a strong sense of loyalty to the military and served his country in various military capacities for many years with distinction.

After returning from the Naval service during the Korean War, he resumed his training in internal medicine. He had an early interest in psychosomatic medicine. It was an energizing field and represented a merging of psychiatry and internal medicine. Special attention was

Continued on next page

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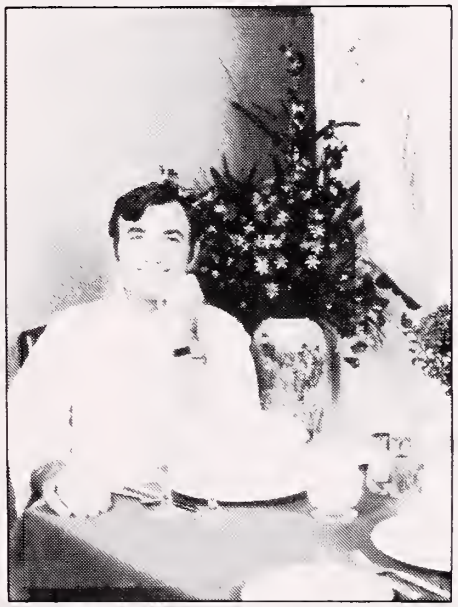

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Continued from preceding page
given to mechanisms of stress and their influence on general health and specific diseases. This early experience led to a life-long interest in headache.

He directed the Headache Clinic for the Department of Medicine until his retirement . He had an encyclopedic knowledge of unusual headaches and their treatment. In this connection, his lectures on headache and pain management were among the best in the medical school. Nonetheless, his most enjoyable avenue for teaching was at the bedside with a few medical students. "Rounding" with Dr Kabler was one of the highlights for junior physicians at the VA or University Hospitals.

He invested much time and energy in the Wisconsin State Medical Society, the Dane County Medical Society, and the American Medical Association. He served as an important link between the university and the physicians of the state. Others today will speak to these facets of his career.

One of his most important achievements was the leadership role he played in the University Health Service. He took over at a time when morale was low, facilities marginal and budget inadequate. When I asked him to take on this responsibility I know I was asking a lot since I had once held the same position.

"Kab" slowly and carefully rebuilt the service and made it the most outstanding in the nation. Not only was he a sound administrator, but he knew the value of the partnership between the medical school faculty and the student health service. In addition, he had a genuine affection for the students and a great respect for their individuality and newly formed adulthood. These decades of service will stand as one of his most appreciated achievements.

He was a "good citizen" in the University community. He served on numerous important medical school, University Hospital, and university committees. He was parliamentarian for the faculty senate for years. His first and almost invariable response was affirmative when asked to take on these added duties.

I have talked in some detail about the things that busied JD over the years, but I haven't said much about what kind of person he was. Let me comment on the "persona." First and foremost, Kab was a careful and systematic man. He always planned thoroughly and as a consequence, had a low error rate in nearly all that he did—his golf swing was a notable exception. He was a fair minded, almost judicial, person who had strongly held views but a high degree of tolerance for opposing opinions. He was very conscientious and honest. Unfortunately, he was so honest he never learned to bluff in poker! JD had a dignity and a touch of old-fashioned formality that blended in an oddly congruous manner with his prairie state friendliness and penchant for humorous one-liners.

If he had a fault it was in keeping his hurts to himself. "Never complain, never explain" was a covert motto. Even though I knew of many of his disappointments and cares, he rarely shared them. This included his worry about an aortic aneurysm.

All of us, friends and family, will miss Kab. I feel especially privileged and grateful to Bea for allowing me to share my thoughts and feelings about my "buddy."

—Peter Eichman, MD
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Caring for the diabetic patient

Samuel Abbate, MD, Marshfield

Diabetes is a chronic illness that requires continuing medical care and education to prevent acute complications and to reduce the risk of long-term complications. Each year, the American Diabetes Association (ADA) publishes Clinical Practice Recommendations for the care of persons with diabetes mellitus. Because the recommendations are published as a supplement to *Diabetes Care*, they are not widely circulated within the primary care community. The recommendations address numerous important issues, including screening for diabetes, nutritional recommendations and principles for individuals with diabetes, gestational diabetes mellitus, exercise, foot care, hypoglycemia, and hospital admission guidelines. Also included are the Standards of Medical Care which define basic medical care for people with diabetes.

The standards provide physicians with the means to set treatment goals, assess the quality of diabetes treatment provided, identify areas where more attention or self-management training is needed, and define timely and necessary referral patterns to appropriate specialists. They provide people with diabetes with the means to assess the quality of medical care they receive, develop expectations for their role in the medical treatment, and compare their treatment outcomes to standard goals. The principles and some of the specific recommendations contained in the Standards of Medical Care are summarized in this article. The author encourages physicians to review the standards in their entirety.

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General principles

Treatment aimed at lowering blood glucose levels to or near normal in all patients is mandated by its proven ability to: reduce the occurrence of diabetic ketoacidosis and hyperosmolar nonketotic coma; relieve the symptoms of hyperglycemia; reduce the development and progression of diabetic retinopathy, nephropathy and neuropathy; and promote less atherogenic lipid profiles.

Achieving near-normal glucose levels requires comprehensive training in self-management and intensive treatment programs. People with diabetes should receive their treatment and care from a physician-coordinated team. Such teams include, but are not limited to, physicians, nurses, dietitians, and mental health professionals with expertise and a special interest in diabetes. Such programs include the following components according to individual patient need: frequent self-monitoring of blood glucose; meticulous attention to meal planning; regular exercise; physiologically based insulin regimens (ie, multiple daily injections of short- and longer-acting insulins or insulin pumps) in IDDM and some NIDDM patients; less complex insulin regimens or oral glucose-lowering agents in some NIDDM patients; instruction in the prevention and treatment of hypoglycemia and other acute and chronic complications; continuing education and reinforcement; and periodic assessment of treatment goals. To be effective, treatment programs require ongoing support from the clinical care team. In situations where resources are unavailable or insufficient, referral to a diabetes care team for consultation, comanagement, or both, is recommended.

Specific goals of treatment

The Diabetes Control and Complications Trial (DCCT) conclusively demonstrated that in patients with IDDM the risk of development or progression of retinopathy, nephropathy, and neuropathy is reduced 50% to 75% by intensive treatment regimens. These benefits were ob-

served with an average hemoglobin A_{1c} of 7.2% in the intensively treated group of patients compared with 9.0% in the conventionally treated group. The reduction in risk of these complications correlated continuously with the reduction in HbA_{1c}. This relationship implies that complete normalization of glycemia levels may prevent complications, and that any lowering of HbA_{1c} would result in a decline in the incidence of complications. Based on the results of the DCCT, self-monitoring blood glucose target ranges were established (see Table). These targets should be adjusted in patients with a history of recurrent severe or unrecognized hypoglycemia.

Individual treatment goals should take into account the patient's capacity to understand and carry out the treatment regimen, the patient's risk for severe hypoglycemia, and other patient factors that may increase risk or decrease benefit (eg, very young or old age, end-stage renal disease, advanced cardiovascular or cerebral vascular disease, or other coexisting diseases that will materially shorten life expectancy).

NIDDM. Thus far, there are no randomized clinical trial results similar to those of the DCCT that prove the benefits of near normalization of blood glucose in NIDDM. Considerable evidence exists, however, for a relationship between microvascular disease and hyperglycemia similar to that proven for IDDM. Therefore, it is reasonable to employ the same glycohemoglobin and blood glucose goals, pending the outcomes of clinical trials that are studying the benefits of achieving such goals in NIDDM. The same individual patient characteristics should be considered as for IDDM.

NIDDM treatment methods should emphasize diabetes management through dietary modification, exercise and weight reduction, supplemented when indicated by glucose-lowering agents, insulin, or both. When insulin treatment is needed, large doses may be required to reach these glycemic targets in some patients, especially in obese insulin resistant patients. There is less certainty that the risk-to-benefit ratio of intensive insulin treatment is as favorable in NIDDM patients as in IDDM patients.

Initial visit

A full detailing of the recommended medical history and physical examination is beyond the scope of this article. The general principles are summarized for the reader.

Medical history. The medical history can uncover symptoms that will help establish the diagnosis in the patient with previously unrecognized diabetes. If the diagnosis of diabetes has already been made, the history should confirm the diagnosis, review the previous treatment, evaluate the past and present degree of glycemic control, determine the presence or absence of the chronic complications of diabetes, assist in formulating a management plan, and provide a basis for continuing care.

An interim history should be obtained at each visit and include: 1) frequency, causes, and severity of hypoglycemia or hyperglycemia; 2) results of self-monitoring; 3) adjustments by the patient of the therapeutic regimen; 4) problems with adherence; 5) symptoms suggesting development of the complications of diabetes; 6) other medical illnesses; 7) currentmedications; 8) psychosocial issues; and 9) lifestyle changes.

Physical exam. The physical examination should be directed at evaluating: the development of eye, kidney, foot, nerve, cardiac, and vascular complications; autoimmune disorders, especially thyroid disease, in IDDM patients; infections in poorly controlled patients; proper growth and maturation in children; and signs of diseases that can cause secondary diabetes, eg, hemochromatosis, pancreatic disease, and endocrine disorders such as acromegaly, pheochromocytoma, and Cushing's syndrome.

At every regular visit, height (until maturity), weight, and blood pressure should be measured. Sexual maturation should be evaluated periodically in peripubertal patients. The fundi should be examined at regular visits (preferably with dilation). If retinopathy is detected for the first time or has progressed or if there are visual symptoms, the patient should be referred to an ophthalmologist or optometrist for a prompt, complete dilated eye and visual examination. The feet should be examined at every regular visit for assessment of vascular status, skin condition, and sensation. If there is evidence of significant ischemia, loss of protective sensation, deformity, ulceration, or infection, the patient should be referred to the relevant specialist for appropriate testing, treatment, or intensive education as indicated.

Laboratory. Blood glucose testing and urine ketone testing should be available in the office. Laboratory tests are obtained to establish the diagnosis of diabetes, determine the degree of glycemic control, and define associated complications and risk factors. These include: 1) fasting plasma glucose (a random plasma glucose may be obtained in an undiagnosed symptomatic patient for diagnostic purposes); 2) glycohemoglobin; 3) fasting lipid profile; 4) serum creatinine in adults; in children if proteinuria is present; 5) urinalysis; 6) microalbuminuria determination (eg, timed specimen or the albumin-to-creatinine ratio) in postpubertal patients who have had diabetes at least 5 years and all patients with NIDDM; 7) urine culture if sediment is abnormal or symptoms are present; 8) thyroid function test(s) when indicated; and 9) electrocardiogram

(in adults).

A glycohemoglobin determination should be performed at least quarterly in all insulin-treated patients and as frequently as necessary to assess achievement of glycemic goals in non-insulin-treated patients. A fasting plasma glucose test may be useful to judge glycemic control in NIDDM patients, and may also be useful for comparison with the value obtained simultaneously by patients using their own monitoring systems.

Lipid profiles should be obtained annually in adults with known abnormalities. The appropriate laboratory measurement should be repeated as needed to monitor patients on lipid-lowering therapy. If all values are within acceptable limits, the clinician may consider obtaining this lipid profile less frequently. A lipid profile should be performed on children older than 2 years, after diagnosis of diabetes and when glucose control has been established. Borderline or abnormal values should be repeated for confirmation. If values fall within accepted risk levels, assessment should be repeated every 5 years. Abnormal values requiring institution of therapy should be repeated following the National Cholesterol Education Program (NCEP) recommendations.[1,2]

Routine urinalysis should be performed yearly in adults. In postpubertal patients who have had diabetes for 5 years, a timed urine collection specimen (eg, 24 hours or overnight) for microalbumin or the albumin-to-creatinine ratio should be measured yearly. If abnormalalbumin or protein excretion is detected, serum creatinine or urea nitrogen concentrations should be measured and glomerular filtration assessed.

Glycemic control for people with diabetes.

Biochemical index	Non-diabetic	Goal	Action suggested
Before meals glucose	< 115	80-120	< 80 > 140
Bedtime glucose	< 120	100-140	< 100 > 160
Hemoglobin A_{1C}	< 6	< 7	> 8

These values are for non-pregnant individuals. "Action suggested" depends on individual patient circumstances. Hemoglobin A_{1c} is referenced to a non-diabetic range of 4.0% to 6.0% (mean 5.0%), standard deviation 0.5%.

Management plan

The management plan should be formulated as an individualized therapeutic alliance among the patient and family, the physician, and other members of the health care team to achieve the desired level of diabetes control. Patient self-management should be emphasized. To this end, the management plan should be formulated in collaboration with the patient, and it should emphasize the involvement of the patient in problem solving as much as possible. When formulating this plan, consideration should be given to the age, school or work schedules and conditions, physical activity, eating patterns, social situation and personality, cultural factors, and presence of complications of diabetes or other medical conditions. Implementation requires that each aspect be understood and agreed upon by the patient and the care providers and that the goals and treatment plan are reasonable.

The management plan should include: 1) statement of short- and long-term goals; 2) medications (insulin, oral glucose-lowering agents, glucagon, antihypertensive and lipid-lowering agents, other endocrine drugs, and other medications); 3) individualized nutrition recommendations and instructions, preferably by a registered dietitian; 4) appropriate lifestyle changes (eg, exercise, smoking cessation); 5) patient and family education for self-management that is consistent with the National Standards for Diabetes Patient Education Programs, preferably provided by a certified diabetes educator; 6) monitoring instructions: self-monitoring of blood glucose (SMBG), urine ketones, and use of a record system; 7) annual comprehensive dilated eye and visual examinations; 8) consultation for podiatry services as indicated; 9) consultation for specialized services as indicated; 10) agreement on continuing support and follow-up and return appointments; 11) instructions on when and how to contact the physician or other members of the health care team when the patient has not been able to solve problems and for management of acute problems; 12) for women of childbearing age a discussion of contraception and emphasis on the necessity of optimal blood glucose control before conception and during pregnancy; and 13) dental hygiene.

The management plan should be reviewed at each regular visit to determine progress in meeting goals and to identify problems. This review should include the control of blood glucose, assessment of complications, control of blood pressure, control of dyslipidemia, nutrition assessment, frequency of hypoglycemia, adherence to all aspects of self-care, evaluation of the exercise regimen, follow-up of referrals, and psychosocial adjustment. In addition, knowledge of diabetes and self-management skills should be reassessed at least annually. Continuing education should be provided or encouraged.

The frequency of patient visits depends on the type of diabetes, the blood glucose goals and the degree to which they are achieved, changes in the treatment regimen, and presence of complications of diabetes or other medical conditions.

Patients initiating insulin therapy or having a major change in their insulin program may need to be in contact with their care provider as often as daily until glucose control is achieved, the risk of hypoglycemia is low, and the patient is competent and comfortable implementing the treatment plan. Some patients may require hospitalization for initiation or change of therapy. Patients beginning treatment by diet or oral glucose-lowering agents may need to be contacted as often as weekly until reasonable glucose control is achieved and thepatient is competent to conduct the treatment program.

Regular visits should be scheduled for insulin-treated patients at least quarterly and for other patients quarterly or semiannually, depending on achievement of treatment goals. More frequent contact also may be required if the patient is undergoing intensive insulin therapy, not meeting glycemic or blood pressure goals, or has evidence of progression in microvascular or macrovascular complications. Patients must be taught to recognize problems with their glucose control, severe hypoglycemic reactions and early signs and symptoms of acute and chronic complications and to promptly report concerns to the health care team. Severe hypoglycemic reactions requiring the assistance of another person must be reported as soon as possible.

Special considerations

Referral for diabetes management. For a variety of reasons, it may not be possible to provide care that meets these standards or achieves the desired goals of treatment. In such instances, the patient should be referred to a diabetologist- or endocrinologist-led diabetes treatment team for consultation, comanagement, or both.

Intercurrent illness. The stress of illness frequently aggravates glycemic control and necessitates more frequent monitoring of blood glucose and urine ketones. Marked hyperglycemia requires temporary adjustment of the treatment program and, if accompanied by ketosis, frequent interaction with the diabetes care team. The patient treated with oral hypoglycemic agents or diet alone may temporarily require insulin. Infection or dehydration is more likely to necessitate hospitalization of the person with diabetes than the person without diabetes. The hospitalized patient should be treated by a physician with expertise in the management of diabetes.

Severe or frequent hypoglycemia. Severe, frequent, or unexplained episodes of hypoglycemia may be due to defective counterregulation, hypoglycemia unawareness, insulin dose errors, or excess alcohol intake. Hypoglycemia may also be a consequence of the therapeutic regimen and always requires evaluation of both the management plan and its execution by the patient. Family members and close associates of patients using insulin should be taught to use glucagon. The successful accomplishment of these goals requires more frequent patient contacts during readjustment of the treatment program and patient and family re-education.

Pregnancy

To reduce the risk of fetal malformations and maternal and fetal complications, pregnant women and women planning pregnancy require excellent blood glucose control. These women need to be seen by a physician frequently, must be trained in self-monitoring of blood glucose, and may require specialized laboratory and diagnostic tests. Consultation with an obstetrician, ophthalmologist, and medical specialist in diabetes is indicated before and during pregnancy. Because of the need for prepregnancy planning and excellent glucose control, every pregnancy in a woman with diabetes should be planned in advance. Therefore, any diabetic woman who is not currently attempting to conceive should be informed of and offered acceptable and effective methods of contraception.

Retinopathy

Comprehensive dilated eye and visual examinations should be performed annually by an ophthalmologist or optometrist for all patients age 12 and over who have had diabetes for 5 years, all patients over the age of 30, and any patient with visual symptoms or abnormalities. Patients with clinically significant macular edema, moderate to severe nonproliferative retinopathy, or any proliferative retinopathy require the prompt care of an ophthalmologist who is knowledgeable and experienced in the management of diabetic retinopathy.

Hypertension

Hypertension contributes to the development and progression of chronic complications of diabetes. Control of hypertension has been shown to reduce the rate of progression of diabetic nephropathy and to reduce the complications of hypertensive nephropathy, cerebrovascular disease, and cardiovascular disease. Lifestyle modifications including weight loss, exercise, reduction of dietary sodium, and limiting consumption of alcohol should initially be employed to reduce blood pressure. If lifestyle modifications do not achieve specified goals, medications should be added in a stepwise fashion. Angiotensin converting enzyme (ACE) inhibitors appear to have selective benefit in patients with diabetes and albumin-

uria.

Hypertension traditionally has been defined as a systolic blood pressure 140 mm Hg, a diastolic blood pressure of 90 mm Hg, or both. In the general population, the risks for end-organ damage are lowest when the systolic blood pressure is <120 mm Hg and the diastolic is <80 mm Hg. The primary goal of therapy for adults should be to decrease blood pressure to <130/85 mm Hg. In children, blood pressure should be decreased to the corresponding 90th percentile values. For patients with an isolated systolic hypertension of 180 mm Hg, the goal is a blood pressure <160 mm Hg. For those with systolic blood pressure of 160 to 179, the goal is a reduction of 20 mm Hg. If these goals are achieved and well tolerated, further lowering to 140 mm Hg may be appropriate.

Nephropathy

The patient with abnormal renal function is at increased risk for end-stage renal disease and cardiovascular disease. Microalbuminuria, persistent albuminuria of 30 to 300 mg/24 hours, is the earliest stage of diabetic nephropathy. Patients with microalbuminuria will likely progress to clinical albuminuria (>300 mg/24 hours) and decreasing glomerular filtration rate (GFR) over a period of years. Once clinical albuminuria occurs, the risk for end-stage renal disease (ESRD) is high in IDDM and significant in NIDDM. Hypertension usually develops during the stages of micro- or clinical albuminuria and, if untreated, can hasten the progression of renal disease.

Specific goals of treatment: Intensive diabetes management has been proven to delay the onset of microalbuminuria by 35% and delay the progression of microalbuminuria to clinical albuminuria by 60%. A reduction in blood pressure will also decrease the rate of progression of diabetic nephropathy. Urinary albumin excretion should be lowered as much as possible in normotensive individuals with elevated excretion rates. Treatment of hypertensive IDDM patients who have microalbuminuria or clinical albuminuria with ACE inhibitors has been shown in clinical trials to delay progression from microalbuminuria to clinical albuminuria and to slow the decline in GFR in patients with clinical albuminuria. Current data suggest that normotensive patients with albuminuria may also benefit from ACE inhibitors.

Urine albumin should be measured on a 24-hour or other timed urine collection, or theratio of albumin to creatinine concentration can be measured in a random urine specimen. Elevation of urinary albumin excretion should be confirmed at least once before initiating specific interventions.

Referral to a physician experienced in the care of diabetic renal disease should be considered when the GFR has fallen to either <70 mL $min \cdot 1.73m^2$ or when serum creatinine has increased above 2.0 mg/dL; or when difficulties occur in management of hypertension or hyperkalemia.

Dyslipidemia

Diabetes increases the risk for atherosclerotic vascular disease. This risk is greatest in persons who have other known risk factors. Daily intake of aspirin has been shown to reduce cardiovascular events in patients with diabetes. A common abnormal lipid pattern in NIDDM patients is an elevation of very-low-density lipoprotein (VLDL), a reduction in HDL, and an LDL fraction that contains a greater proportion of small, dense atherogenic LDL particles.

A meal plan designed both to lower glucose levels and to alter lipid patterns along with regular physical activity are the cornerstones in the management of lipid disorders. The goal of nutrition therapy should focus on three major strategies: weight loss if indicated, increased physical activity and meal plan recommendations individualized for the patient.

Data about treatment of dyslipidemia in people with diabetes, especially in children, are limited. Because diabetes appears to eliminate the protective effect of female gender against CHD, all adults with diabetes are candidates for progressively aggressive therapy. The primary emphasis in children and adolescents with serum lipid abnormalities should be on glucose control, diet, and exercise. Drug therapy in these children and adolescents should only be undertaken in consultation with a physician experienced in the area of lipid disorders in children.

Specific goals of treatment: The primary goal of therapy for diabetic patients is to lower LDL cholesterol to <130 mg/dL. The primary goal of therapy in people with known CHD is to lower the LDL cholesterol to 100 mg/dL and triglycerides to 200 mg/dL. People with diabetes who have triglyceride levels 1,000 mg/dL are at risk for pancreatitis and other manifestations of the hyperchylomicronemic syndrome. These individuals need special, immediate attention to lower triglyceride levels to <400 mg/dL. Further reduction to NCEP goals of <200 mg/dL may be beneficial. A secondary goal of therapy is to raise HDL cholesterol to >35 mg/dL in men and >45 mg/dL in women. The primary goal of therapy for children with risk factors in addition to diabetes is to lower LDL cholesterol to <160 mg/dL.

Neuropathy

Peripheral diabetic neuropathy may result in pain, loss of sensation, and muscle weakness. Autonomic involvement can affect gastrointestinal, cardiovascular, and genitourinary function. Each condition may require special diagnostic testing and consultation with an appropriate

medical specialist. Improvement in neuropathy should be sought by increased attention to blood glucose control. Relief can be provided by various medications, alterations in meal plans or dietary intake, or specialized procedures.

Problems involving the feet may require care by a podiatrist, orthopedic surgeon, vascular surgeon, or rehabilitation specialist experienced in the management of people withdiabetes. All patients, especially those with evidence of sensory neuropathy or peripheral vascular disease, must be educated about the risk and prevention of foot problems, and this education must be regularly reinforced. Patients with a history of previous foot lesions, especially those with prior amputations, require preventive foot care and lifelong surveillance preferably by a foot care specialist.

Conclusion

As medicine moves into an era of managed care, standards will need to be developed for the care of chronic illnesses. Diabetes serves as a model condition for this process. The mission of the ADA is to prevent and cure diabetes and to improve the lives of all people affected by diabetes. As part of fulfilling this mission, the ADA has developed its Clinical Practice Recommendations with the best care of the patient as the primary focus. It is hoped that these recommendations will be adopted by managed care organizations and the National Committee on Quality Assurance.

The ADA standards define appropriate care for persons with diabetes and this care will ultimately provide important cost savings to the medical system. The CDC projected that if 1 million persons with diabetes received treatment similar to that practiced in the DCCT, this would result after nine years in 200,000 fewer cases of retinopathy and nephropathy and 100,000 fewer cases of neuropathy. Managed care systems must be encouraged to take a long-term view of diabetes care and not just look at the short-term cost of care. Significant cost savings to the system come from the prevention of long-term complications. Prevention of these complications will more than offset the short-term increase in costs from appropriate care including diabetes education.

To receive a copy of the Clinical Practice Recommendations or to learn how to become a professional member of the ADA and receive publications such as *Diabetes Care*, call 1-800-DIABETES (342-2383). Please refer to this article.

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The gynecological manifestations of Crohn's disease

John D. Watson, MD, Milwaukee

SYSTEMIC DISEASES MAY have gynecologic symptoms. In primary care, knowledge of systemic disease associated with gynecologic conditions assumes increasing importance. A case of Crohn's disease with multisystem organ involvement is described and a brief review of the gynecologic manifestations of Crohn's disease presented.

Case report

A 36-year-old gravida-6, para-3, AB-3 woman was admitted to the hospital in May 1994 with complaints of having had fever for 2 days, pain and swelling of the right knee for 1 week, and menorrhagia of 4 years' duration.

Physical findings at the time of this admission: temperature 101°F, blood pressure 110/64, pulse 80, and respirations 18. A functioning colostomy was noted in the right mid quadrant. The right knee was swollen and tender with limited range of motion. A gynecologic examination could not be performed because of patient discomfort. Other than a normochromic-normocytic anemia of 6.2 grams percent, no hematologic abnormalities were detected.

Shortly after admission, a dilation and curettage and examination under anesthesia were performed. Extensive vulvar involvement with Crohn's disease was present, with findings of cellulitis, fistulous tracts, edema, and erythema as noted in the figure. The uterus sounded to 8 cm and was grossly normal in size. No adnexal masses were appreciable. The pathology report indicated secretory endometrium without evidence of hyperplasia or atypia.

An intra-articular injection of 20 mg of Aristospan was administered into the right knee joint after 30 mL of fluid had been aspirated. Depo-Provera 150 mg intramuscularly was given to suppress menses in hopes of improving the patient's anemia.

In 1985 the patient was admitted to the hospital on two occasions for perirectal and vulvar abscesses. A colonoscopy was performed in November 1985 and the diagnosis of Crohn's disease confirmed by rectal biopsy. The patient was admitted to the hospital on seven occasions from 1985 to 1990 for recurring vulvar and perirectal abscess formation with associated skin fistulization secondary to Crohn's disease of the vulva. On several occasions, incision and drainage of abscesses was required. A double-barrel colostomy was performed in July 1990 in hopes that diversion of the fecal stream would facilitate perineal healing.

Perineal abscess formation continued and in January 1991 a colostomy revision with end colostomy, transverse and left hemicolectomy and low anterior resection of the large bowel were performed. The patient continued to have perineal infections, and in April 1991 a completion proctectomy and perineal resection of the rectum were necessary.

Despite these procedures, five more admissions were required over the next 3 years to treat various manifestations of Crohn's disease including vulvar abscesses. Multiple courses of antibiotics were required to treat recurring infections. Additionally, intermediate arthritis of the right knee was treated with anti-inflammatory agents and intra-articular corticosteroid injections. A chronic anemia was evaluated by numerous hematologic tests including bone marrow aspiration. The anemia was felt to be of mixed etiology with elements of iron deficiency, chronic disease, and thalassemia. Vitamins, iron, and erythropoietin were administered with limited success. Numerous other medications including metronidazole, sulfasalazine, and intermittentsteroids were administered over 8 years for exacerbations of Crohn's disease with mixed results. Lack of patient compliance, refusal of blood products, and cocaine use compounded the difficulty of therapy.

A vulvectomy with perineal reconstruction was performed in July 1994 because of unremitting vulvar pain and inability to have intercourse. Three months after surgery, the patient's vulvar pain abated and she was able to have intercourse.

Discussion

Crohn's disease occurs frequently in the United States with an incidence of 5 per 100,000 and a prevalence of 50 per 100,000.[1] The incidence of the disease has risen over the past 20 years. Although originally ascribed to the terminal ileum, it is now clear that Crohn's disease may involve any part of the gastrointestinal tract. Nonspecific extraintestinal manifestations may involve the lips, mouth, anus, skin, liver, or bones.[1] The disease affects men and women equally and is present among all age groups. The peak incidence of the disease is in the second and third decades.[1] As a gynecologic finding, Crohn's disease presents either as a pelvic mass or more commonly as a dermatol-

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ogic condition. The pelvic mass may present secondarily by virtue of gastrointestinal involvement or primarily by involving the fallopian tubes and ovaries. Granulomatous salpingitis and oophoritis secondary to Crohn's disease have been reported previously.[2,3] Histologically, a highly atypical proliferative lesion of the fallopian tube might mimic tuberculosis or carcinoma in situ.[2]

Skin involvement in Crohn's disease is the most frequent extraintestinal gynecological manifestation with an incidence of 11% to 44% and has been reported in children as well as in adults.[4,5,6] Dermatologic involvement occurs by direct extension from involved bowel as peritoneal ulceration, ischiorectal abscess and fistulization, or by "metastatic" granulomas which are separated from the gastrointestinal tract by normal tissue.[4] Histologic confirmation is necessary in cutaneous cases to exclude other similar appearing diseases such as lymphogranuloma venereum, hidradenitis suppurativa, actinomycosis, vulvar tuberculosis, sarcoidosis, and leprosy.[4]

The initial management of Crohn's disease includes metronidazole, corticosteroids, sulfasalazine, and azathioprine with surgery reserved for unresponsive cases.[1,2,5] Treatment of extraintestinal Crohn's disease is difficult. Laparotomy with appropriate extirpative or reconstructive surgery is often necessary when intrapelvic manifestations of the disease are present. Since the original description of Crohn's disease of the vulva, less than 20 cases have been reported in the English literature; the treatment of choice has not been established.[2,7]

In summary, important gynecological considerations (not all of which were relevant in the case presented) in distinguishing Crohn's disease from other processes include:

- Crohn's disease must be considered in the differential diagnosis of a pelvic mass.
- Involvement may be severe enough to cause infertility.
- An erroneous diagnosis of carcinoma of the fallopian tube may be made if the highly atypical proliferative lesion of granulomatous salpingitis is present.
- Biopsies of suspicious vulvar lesions must be performed to confirm the diagnosis of Crohn's disease.

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GUEST EDITORIAL

By Robert E. McAfee, MD
President, American Medical Association

On March 9, medicine scored one of its biggest legislative victories ever when the House of Representatives, in a bipartisan vote, approved an AMA-backed amendment that would place a $250,000 cap on pain-and-suffering awards in medical malpractice cases.

This historic vote came as a result of an all-out lobbying effort by your American Medical Association and many other medical organizations. It was a blockbuster victory for the AMA, the medical profession, and every practicing physician.

Liability reform has been at the top of medicine's legislative agenda for as long as most of us can remember. Now, after 20 years of tirelessly campaigning, we can claim a major win in Washington.

That's the good news. The not-quite-so-good news is that the legislation still has to go before the Senate, where the proposal is certain to be a prime target of the trial lawyers' lobby. So our task is only half complete. The vote there is likely to take place in the next few weeks, and before then we'll probably be calling on all of you to contact your senators and let them know where you stand.

Meanwhile, here are some of the things we've done, and are continuing to do.

1. We've mobilized the efforts of state and county medical societies and national specialty organizations to join us in this effort. In late March we sent a letter to every Senator that was signed by the medical societies of all 50 states and the District of Columbia and by 81 specialty societies, demonstrating their unity in calling for tort reform. In addition to limits on damage awards, we are seeking an expansion of the joint-and-several liability reforms to all defendants, not just those who sell products. The AMA Alliance also sent letters to every county legislative chair in the home districts of members of the Senate Judiciary Committee, urging them to call and fax their support for liability reforms.

2. We've gone directly to Capitol Hill. We urged state societies to contact their representatives one-on-one in their districts during the Presidents' Day recess, and many did so. During our recent National Leadership Conference in Washington, we held a reception for members of Congress and followed that up with one-on-one visits with members of Congress by physicians and delegations of physicians.

3. We've also gone public with our message. We've sponsored drive-time ads on Washington's top radio stations, rebutting some scare tactics used by the trial lawyers. We've placed print ads in the Wall Street Journal and in Capitol Hill publications. And we've sent our message to the editorial writers at all of the nation's top newspapers, with facts to back up our arguments.

The public is listening. A Gallup survey showed that more than 71% of Americans favor liability reforms, including caps on pain and suffering awards. Clearly, many of our patients are on our side. But we can take nothing for granted.

Tell your patients! Tell your colleagues! Tell your representatives in Congress! The AMA and organized medicine throughout the U.S., are leading the more than 700,000 physicians of America in the battle for liability reform. Congress must know we will not stop until the job is done.

As this is being written, liability reform is at the top of our priorities. But Medicare reform and the AMA's 1995 Patient Protection Act also will receive our major attention in the coming days and months.

Together, organized medicine is fighting for legislation that will allow you to care for your patients to the best of your ability and conscience. I invite all of you to join us in that fight.

(For additional information on the AMA's legislative programs or for materials suitable for sharing with your patients, contact the AMA Dept. of News and Information, 312/464-4430.)

An unusual sonographic appearance of a chronic renal peritransplant lymphocele

Bart J. Schmidt, MD, and Andrew J. Taylor, MD, Milwaukee

Lymphoceles are the most common renal peritransplant collections. They typically develop and progress within 6 months of transplantation. Clinical presentation is varied and includes azotemia, lower extremity edema, fever, weight gain, tenderness over the allograft, palpable mass, and thromboembolic complications. Herein, we present a chronic peritransplant lymphocele with unusually thick and irregular internal septae which could easily be mistaken for other complex peritransplant or pelvic masses. In this case, color Doppler flow imaging helped to limit the differential diagnosis as well as to guide appropriate intervention. Additionally, we describe the pathophysiology of lymphocele formation and treatment options. *Wis Med J.1995;94(4):206-208.*

Lymphoceles, the most common renal peritransplant fluid collections, can lead to significant morbidity in the transplant patient. Complications include transplant hydronephrosis, azotemia, and allograft demise. Because of the trend for treatment of lymphoceles by percutaneous aspiration or tube drainage,[1] differentiation from other peritransplant fluid collections is an increasingly important issue. Sonographically, lymphoceles usually appear as anechoic or hypoechoic peritransplant collections, occasionally containing thin internal septae and dependent debris. We present a case of a chronic renal peritransplant lymphocele with unusually thick and irregular internal septae which could easily be mistaken for other complex cystic peritransplant or pelvic masses. In this case, color Doppler flow imaging (CDFI) helped to limit the differential diagnosis as well as to guide appropriate intervention.

Dr Schmidt and Dr Taylor are with the department of radiology at the Medical College of Wisconsin.Reprint requests to: Andrew J. Taylor, MD, Medical College of Wisconsin, Department of Radiology, DH-151, 8700 W Wisconsin Ave, Milwaukee, WI 53226. Copyright 1995 by the State Medical Society of Wisconsin.

Case report

A 28-year-old renal transplant patient had new onset hypertension. Biochemical serum analysis revealed a creatinine of 2.2 mg/dL, mildly elevated from a baseline of 1.6. He had undergone cadaveric renal transplantation 7 years previously for end-stage renal disease from Alport's syndrome. The postoperative period was complicated by a small, 2 × 3 cm, anechoic peritransplant fluid collection which was not treated.

At admission, a 10.0 x 8.5 x 9.3 cm complex cystic mass was found anteromedial to the renal transplant on gray scale ultrasonography (Quantum 2000 [Siemens], Issaquah, Wash) corresponding to the location of the original fluid collection identified in the peritransplant period. Markedly thick and irregular septae were noted in the mass (Fig 1). Renal transplant hydronephrosis was also present. In addition, a smaller hypoechoic mass was identified deeper to this larger, complex mass (Fig 1).

On color Doppler flow imaging, no significant blood flow was detected in the septae or around the periphery of this well-marginated mass. Analysis of the interlobar and segmental renal transplant arterial waveforms revealed no evidence of rejection. The arterial anastomosis was also visualized with no evidence of stenosis. Fluid obtained from percutaneous fine needle aspiration of the complex mass showed a biochemical profile consistent with a transudate of serum. Gram stain and cultures eventually proved negative.

Operative incision and debridement was performed. The fluid was described as thick and yellowish. Additionally, thick, "curdled" material was removed from dependent areas. Cytochemical analysis revealed characteristics comparable with those obtained at fine needle-aspiration. The patient was discharged on the fifth postsurgical day with a return of his renal function and blood pressure to baseline.

Discussion

Lymphoceles account for upward of 80% of renal peritransplant fluid collections in some series[2] and they complicate approximately 20% of all transplantations.[3] Typically, they are identified subacutely (within 6 months), but cases of delayed development or detection are well-documented in the literature.[3]

Most small peritransplant lymphoceles will undergo spontaneous involution, while larger collections will typically require treatment. Therapeutic options include repeated needle aspiration, percutaneous catheter drainage with or without sclerosant instillation, surgical peritoneal windowing and, more recently, laparoscopic peritoneal drainage.

Percutaneous catheter drainage and surgical peritoneal windowing

are the most popular treatment regimens, with reported success rates as high as 86% and 89%, respectively.[4,5] Successful percutaneous catheter drainage of lymphoceles requires relatively more time (18-day average) than abscesses and other standard fluid collections (5 to 15 days).[6] This is intuitive if one considers the time requirements for weeping or leaking lymphatics to heal. Some groups routinely instill sclerosants (tetracycline, ampicillin, or providone-iodine) into the cavities while others advocate this practice only for difficult cases.

Smaller lymphoceles are usually detected coincidentally during transplant sonography performed for the evaluation of rejection. Larger or strategically located lymphoceles may present clinically in many different ways—azotemia, lower extremity edema, fever, weight gain, tenderness, palpable mass, or with thromboembolic complications.

Although abdominal and upper retroperitoneal lymphoceles may contain chlyous fluid derived from the bowel, pelvic lymphoceles are essentially ultrafiltrates of plasma, and biochemistries obtained at needle aspiration reflect this. Seromas will have a similar biochemical profile, but the fluid will appear serosanguineous. Urinomas have increased levels of urea nitrogen and creatinine.

The pathogenesis of lymphoceles appears to depend on the chronology of development. Those found during the first several months after transplantation appear to be related to surgical disruption of the recipient's lymphatics that occurs during extraperitoneal dissection. This pathophysiology is supported by studies using lymphography to illustrate the abnormal postoperative lymph flow dynamics.[7] The increased incidence of lymphoceles observed with retransplantation adds further support to this theory.[8]

The pathogenesis of late-appearing, chronic lymphoceles is distinct from that of subacute lymphoceles. In the chronic form, dilated intraparenchymal lymph vessels are present histologically. Since renal parenchymal lymph exits via the hilum, an obstructing process at this level would seem to be the etiology in these cases.[3] In fact, Thompson and Neale[3] reported a case in which there was extensive hilar fibrosis, presumably on the basis of chronic rejection, with lymph weeping from the transplant seen at surgical exploration.

Lymphoceles can vary in appearance from well-circumscribed, completely anechoic, unilocular cystic masses to complex structures with markedly thickened and irregular septae as seen in this case. To date, there have been no studies reviewing characteristics of the septae in lymphoceles despite the potential confounding nature of this internal architecture with respect to differential diagnosis.

Since hematomas, abscesses, and urinomas do not usually come to clinical attention inthe chronic phase after transplantation, the main considerations of a late-appearing complex, cystic mass in the transplant patient consists of benign and malignant ovarian neoplasms, endometriomata (Fig 2), ectopic gestations, iliac artery aneurysms, var-

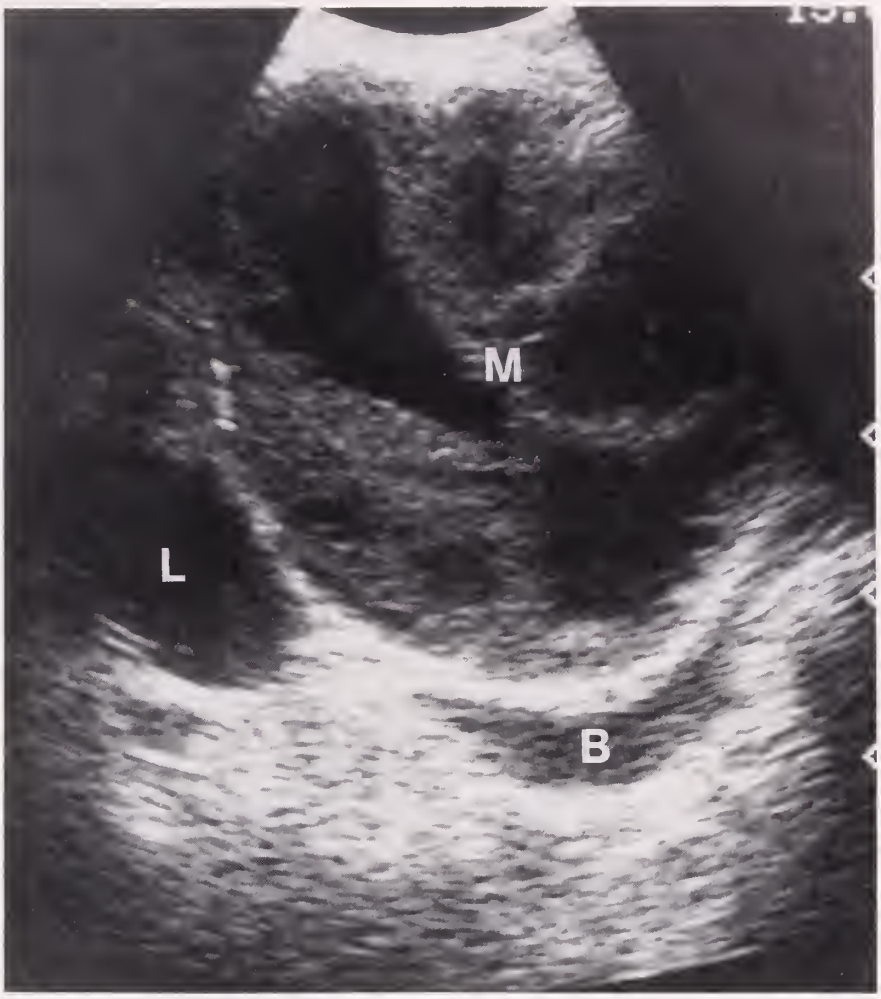

Fig 1.—Transverse gray scale sonogram medial to the renal transplant reveals a complex, cystic mass (M) with markedly thick and irregular septae. This eventually proved to be an atypical lymphocele. There is compression of the urinary bladder (B). A hypoechoic lymphocele (L) is noted deeper in the pelvis.

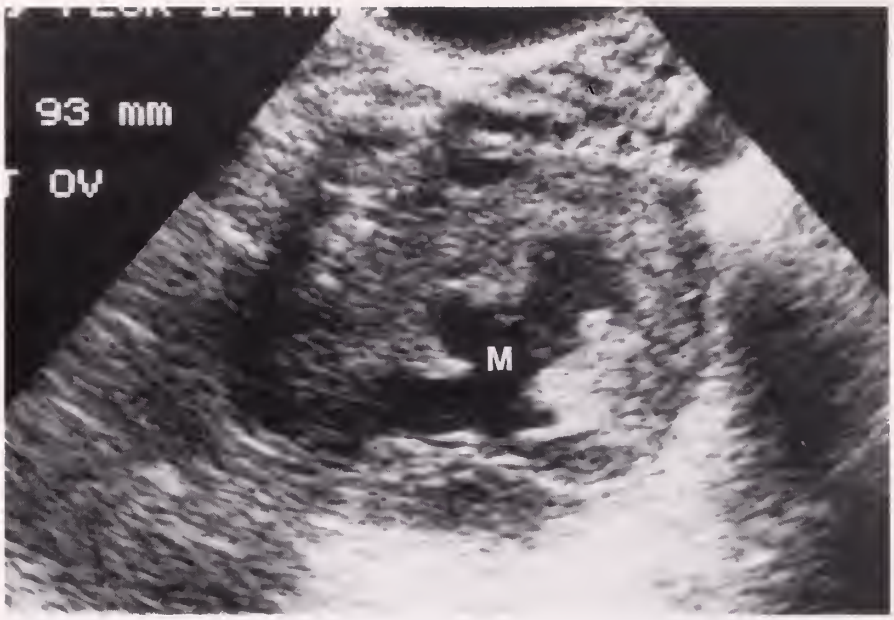

Fig 2.—A transverse sonogram of the left adnexal region in another patient reveals a complex cystic mass (M) with thickened, irregular septae. This proved to be an endometrioma. Notice the similarity to the atypical lymphocele in Fig 1.

ices, and abnormalities of the native or transplanted urinary tract. Since most benign and malignant ovarian neoplasms contain septal and peripheral flow on CDFI, they should not be confused with complex, atypical lymphoceles.[7] Endometriomata and ectopic gestations also characteristically demonstrate increased peripheral flow.[9,10,11]

Abnormalities of the native or transplanted urinary tract should not demonstrate thick and irregular septations. If a complex structure is felt to originate from the urinary tract, CT with retrograde opacification of the urinary bladder or intravenous contrast should be employed. If this is not diagnostic, fine needle aspiration will yield an abnormally high creatinine.

Differentiating this unusual lymphocele appearance from other complex, cystic peritransplant masses becomes particularly important when intervention is contemplated. Needle aspiration of malignant ovarian neoplasms can lead to peritoneal seeding and pseudomyxoma peritonei if the cell type is mucinous. Additionally, a needle aspiration biopsy of vascular neoplasms or of an iliac artery aneurysm could obviously result in significant bleeding. In these instances, just as in the present case, CDFI will help define management options.

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Public health

The Wisconsin Diabetes Control Program: a health systems and community-based approach

Patrick L. Remington, MD, MPH; Nancy Chudy, MPH; Thomas Conway; and Susan Wood, Madison

Diabetes is the fourth leading cause of death in Wisconsin, costing an estimated $1.8 billion in health care costs and lost productivity. Each year, more than 3,500 Wisconsin residents die from diabetes and many more suffer disabling complications, such as end-stage renal disease, blindness, and amputations. Wisconsin's *Public Health Agenda for the Year 2000* has set following goals for the year 2000:

- to reduce morbidity and mortality associated with diabetes;
- to reduce the incidence and prevalence of diabetes among adults by preventing and controlling diabetes;
- to reduce the incidence of the complications of diabetes, including diabetic ketoacidosis, amputations, blindness, cardiovascular disease, and renal disease;
- to increase access to preventive care for diabetics.

To help reach these objectives, the Wisconsin Division of Health has established the Wisconsin Diabetes Control Program, with funding from the Centers for Disease Control and Prevention. The Wisconsin Diabetes Control Program will address the following four components.

I. Define the burden of diabetes through surveillance and epidemiology

Epidemiology and surveillance will serve as the foundation of Wisconsin's Diabetes Control Program. This assessment role is an essential function of public health. Data on the burden of diabetes and its complications will be used to formulate health care policy, identify high risk groups, target interventions, advocate for greater resources, ensure the delivery of state-of-the-art preventive care, and evaluate the effects of programs. Preliminary assessment of the existing data on diabetes in Wisconsin reveals the following:

Diabetes mortality in Wisconsin is one of the highest in the nation, ranking 11th among all states during 1980-1988.[1] Over the past decade, the diabetes-related mortality rate in Wisconsin has increased 10%, from 65.7 to 72.3/100,000, whereas the national rate has remained constant. The reason for this increasing death rate is not known.

Diabetes is the fourth leading cause of death in Wisconsin, contributing to more than 8% of deaths in the state. In 1992, 1,043 deaths listed diabetes as the underlying cause, and anadditional 2,423 listed diabetes as a contributing cause. Diabetics in Wisconsin are more likely to smoke cigarettes, and thus have substantially higher risk of cardiovascular disease.[2]

Diabetes is more common among American Indians in Wisconsin. A health status survey of the Chippewa in 1990 found that 11% of men and 17% of women reported that they had diabetes, compared with about 5% in the general population.[3]

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The death rate for diabetes among American Indian women in Wisconsin is five times higher than the rate among all women in the state (107 v 22/100,000).

Hospitalization charges for diabetes exceed $50 million annually. Each year, more than 6,000 persons are hospitalized with a principal diagnosis of diabetes.[4] The average length of stay for each of these admissions is 7 days and the average charge is $8,000, leading to annual charges of $50 million.

Diabetes is the leading cause of end-stage renal disease in Wisconsin.[5] The cost of maintaining a patient on long-term dialysis exceeds $32,000 per year.

Diabetes is the most common cause of non-traumatic lower limb amputation. Each year, an estimated 1,000 persons in Wisconsin require an amputation of a foot or leg as a result of diabetic complications.[4] In 1992, the average hospitalization lasted 14 days and charges for each stay were more than $15,000. The total charges for diabetes-related amputations exceeded $18 million.

Diabetes is the leading cause of blindness in people ages 20-44 and the second leading cause among persons 45-74.[6] Each year, an estimated 300-800 people in Wisconsin lose their sight because of diabetes.[7]

II. Improve opportunities for diabetes prevention and control through the health care system

A second component of the diabetes control program will by to improve opportunities for diabetes prevention and control through the existing and evolving health care system. The changes in the health care system that are likely to take place over the next several years will alter how health care is delivered to those with diabetes. With this evolution, the role of public health will likely shift from one of direct service provision to one of outreach, referral, and integration. Because of the recent scientific evidence that rigorous glycemic control can delay the onset and slow the progression of diabetic complications, new strategies must be developed to ensure that all persons with diabetes--regardless of age, race, or insurance coverage--benefit from these advances.

Accordingly, the Wisconsin Diabetes Control Program will provide leadership in efforts to reduce the burden from diabetes in a managed care setting. The following describes a preliminary assessment of the barriers to diabetes care in primary care:

Physician barriers. Most physicians who treat diabetics are primary care providers. Many do not have a large enough caseload of diabetics to feel comfortable about new treatment and self-management techniques. Often, other health professionals such as dietitians and diabetes educators, are not available in private practices to assist in diabetic care.

Lack of health care access. As in many states, many of Wisconsin's residents with diabetes eitherlack a primary care provider or do not have adequate insurance. This is especially true in rural areas and among Wisconsin's urban poor.

Payment for services. Wisconsin is one of only a few states that mandates preventive diabetes care for health insurance providers, including coverage for expenses incurred by the installation and use of an insulin pump, coverage for all other equipment and supplies used in the treatment of diabetes, and coverage of diabetic self-management programs.[7] Nevertheless the actual use of these services in clinical practice is unknown.

III. Develop community-based interventions for diabetes control

A third component of the program will be to increase opportunities for prevention, detection, and control of diabetes in communities. These efforts will be focused on high-risk populations. This component of the program will take a "bottom up" approach to reduce the burden from diabetes, by building a supportive local environment where people with diabetes live and work. By taking a community-based approach, these prevention programs will target those who are already diagnosed with diabetes (to improve their control and reduce the need for treatment) as well as those at high risk for developing the disease. As outlined in the previous section, this component of the program will focus on American Indians, blacks, Hispanics, and the elderly, and will address the following issues:

Lack of awareness. The majority of adult-onset diabetes can be prevented by avoiding obesity through exercise and eating a healthy diet.[8] Despite this, many individuals who are at risk of developing diabetes, such as those with a family history,

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do not adopt these preventive practices. Many individuals are not aware of the risk factors associated with diabetes, the signs associated with diabetes, and the seriousness of the disease. Those individuals at risk for diabetes may not even be aware they have the disease until it has progressed to many of its associated complications.

Diabetes self-management barriers. Many diabetics do not practice sound self-management techniques, and place themselves in additional risk for complications by noncompliance with exercise and diet prescriptions. Many could improve their control of diabetes by adopting healthier lifestyles.

Lack of community-based services. Most individuals look to their community for prevention services, such as exercise and nutrition programs. In Wisconsin, there has been a lack of these community-based services, especially in areas at high risk for diabetes, such as rural counties and inner cities. In fact, Wisconsin received its lowest ranking (36th of 50 states) for its lack of community services and programs in the Diabetes Index.[7]

Cultural and social barriers. Minorities are at substantially increased risk of diabetes and diabetes complications, but culturally appropriate information, care guides, and treatment plans are not common, or if they exist, they may not been disseminated through appropriate channels. Other barriers, such as language, transportation, and child care are rarely addressed.

IV. Coordinating statewide diabetes control efforts

The final mission of Wisconsin's Diabetes Control Program will be to provide statewideleadership for diabetes control. In the past, the American Diabetes Association has been the only organization providing leadership in the state. The Wisconsin Diabetes Control Program will build on this experience by providing state-based data on the burden of diabetes and by engaging the public health system in diabetes control.

During the first year of the program, staff will define the burden of diabetes, establish a diabetes advisory committee, and build the diabetes network in the state. Work groups will be established to determine the needs for diabetes control in the evolving health care system and in communities at high risk for

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diabetes. During the second year, a needs assessment will be conducted and the Diabetes Control Plan will be completed, setting priorities for funding for years 3 through 5. Priority will be given to areas of greatest need, and to organizations that demonstrate commitment by providing matching funds or planning to institutionalize the program. By the end of the fifth year, an evaluation will be conducted to determine if the objectives were met, and if not, why not.

Summary

The Wisconsin Diabetes Control Program will address the health needs of people with diabetes by working closely with the Wisconsin Affiliate of the American Diabetes Association and other diabetes health professionals in the state. The 5-year program will use both health systems and community-based approaches to coordinate prevention, detection, and control activities required to reduce the burden of this chronic condition. This program represents a major shift in focus from previous diabetes control programs supported by the CDC, and is designed to establish the program as a key component of an evolving health care environment.

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Unisys Corp to replace EDS as Medicaid fiscal agent

Unisys Corp., in connection with Blue Cross Blue Shield of Wisconsin, has been selected as the next Medicaid fiscal agent for the $2.3 billion-a-year program. Replacing EDS, the new contractors will enter an 18-month implementation phase this summer, followed by three years of operating as the state's Medicaid claims processor. The other two bidders were EDS and Wisconsin Physicians Service, which teamed with Anderson Consulting on its proposal. The winning bid was $89.9--significantly lower than the competing bids. In 1994, the state's MA providers submitted 14 million claims for the program's nearly 500,000 recipients.

Medicaid officials say that contract negotiations will begin as soon as possible. The SMS will work with Medicaid officials to identify needed improvements in claims processing, prior authorization, provider services and publications.❖

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DIABETES
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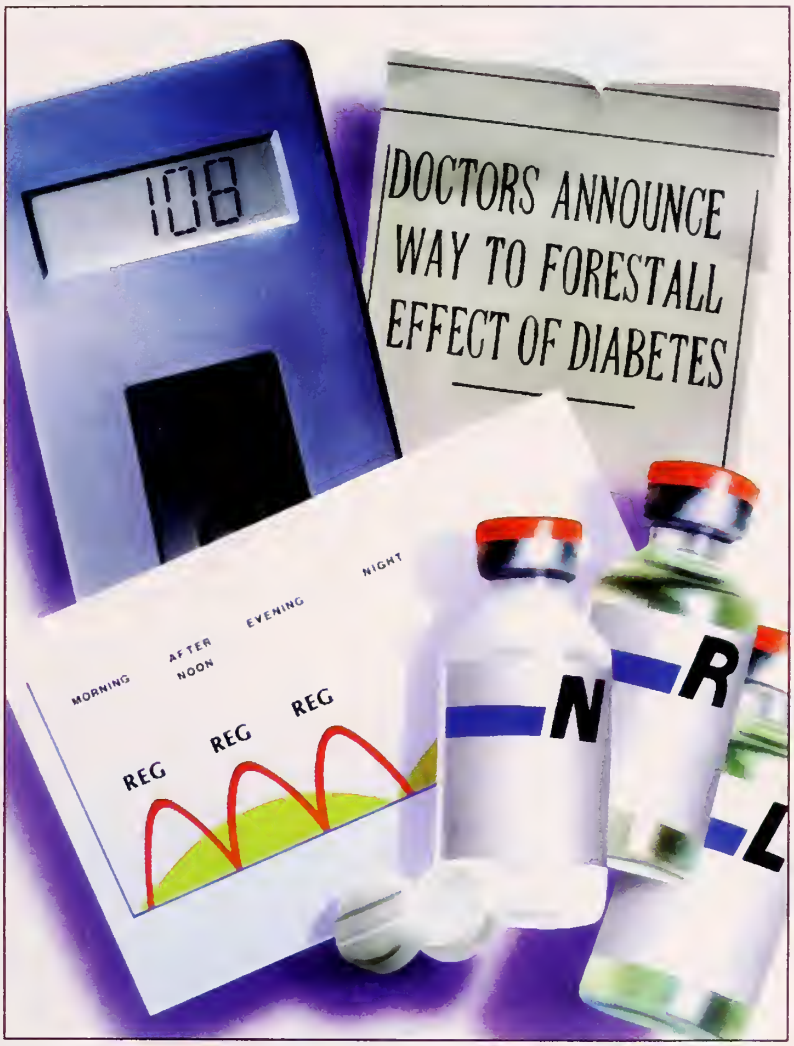

Upgrading Diabetes Therapy

...now that we know it matters

What every primary care physician needs to know

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The worldwide leader in diabetes care

Developed in collaboration with the Joslin Diabetes Center

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All changes in insulin or other diabetes medications should be made cautiously and only under medical supervision.

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THE DEBATE IS OVER

In the spring of 1993, researchers called an early halt to the Diabetes Control and Complications Trial, or DCCT. Launched in the early 1980s, this multicenter study was designed to resolve, once and for all, whether "tight" blood glucose control can help prevent or slow the progression of long-term complications of diabetes, including eye, nerve, and kidney disease. The answer, in short, is **yes.**[1]

THE DCCT DESIGN

In the DCCT, 1,441 volunteers with type I (insulin-dependent) diabetes, ages 13–39, were randomized to one of two diabetes management plans:

- "conventional" therapy, with one or two injections per day, once-daily monitoring of blood or urine glucose, dietary education, and four physician visits a year;
- "intensive" therapy, involving three or more injections per day, or use of an insulin pump, with dosages adjusted on the basis of four or more daily blood glucose tests; intensive diabetes education and dietary, exercise, and psychosocial counseling; and monthly physician visits.

Basic clinical goals

For conventional therapy: "Clinical well-being"—no symptoms of high or low blood sugar; normal growth and development.

For intensive therapy: Blood glucose levels as close to normal as possible.

WHAT THE STUDY SHOWED

Benefits of intensified control

Both groups were monitored for signs of eye, nerve, or kidney disease. Overall, the intensive therapy group experienced a profound reduction in long-term complications.

Intensive therapy reduced

- retinopathy by up to 76%;
- nephropathy by up to 56%;
- neuropathy by up to 60%.

Overall, the intensive therapy group experienced a profound reduction in long-term complications.

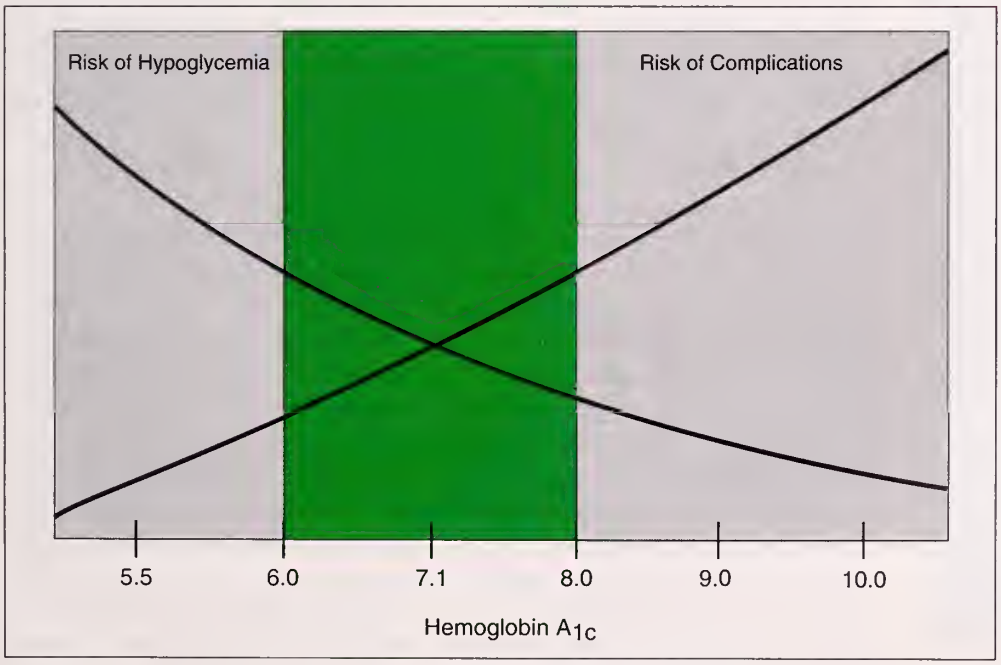


Figure. Artist's conception of principal DCCT findings. Based on results reported in *N Engl J Med* 1993;329:977-986.

The goals you and your patients set *today* for glycemic control can influence your patients' *future* health *substantially*.

The lower the average glycosylated hemoglobin levels (see Figure), the lower the risk for long-term complications.

Risks of intensified control

Despite frequent self-monitoring of blood glucose (SMBG) and close contact with the healthcare team, the intensively treated patients had *three times* as many severe hypoglycemic episodes (those requiring assistance from someone else or emergency room visits) as the conventionally treated patients.

Intensive treatment also promoted weight gain: After five years, intensively treated patients had gained approximately 10 pounds more than conventionally treated patients over the same period.

WHAT THE FINDINGS MEAN TO YOU

The goals you and your patients set *today* for glycemic control can influence your patients' *future* health *substantially*.

DOES THIS APPLY TO ALL PATIENTS?

The DCCT subjects all had insulin-dependent diabetes mellitus (IDDM), also called type I or (formerly) "juvenile-onset" diabetes. This disorder completely destroys a person's insulin-making capacity; insulin therapy is needed for survival. Roughly 300,000 people in the United States have this form of diabetes, which usually develops in youth or early adulthood.

The great majority of people with diabetes have a more common form of the disorder, known as non–insulin-dependent diabetes mellitus (NIDDM), also called type II or (formerly) "maturity-onset" diabetes. This disease usually strikes people who are older than 40 and overweight. Some 6.5 million Americans are known to have NIDDM, and it's estimated that another 6–7 million cases remain undiagnosed.

Although the DCCT findings directly apply only to patients with IDDM, the American Diabetes Association (ADA) has stated that

> **it seems reasonable to recommend tight control in many patients with non–insulin-dependent disease because it is presumed that the mechanisms by which glucose causes complications is the same in both forms of diabetes.[2]**

Although it can persist for years with few or no symptoms, NIDDM is not a "mild" form of diabetes. It also carries a great risk for chronic complications.

WHAT ABOUT OTHER COMPLICATIONS OF DIABETES?

People with diabetes are at increased risk for atherosclerosis—and thus for coronary disease, stroke, and peripheral vascular disease. These complications appear to be less tightly tied to glycemia than eye, nerve, and kidney complications; serum cholesterol and lipids, blood pressure, and smoking history also contribute to macrovascular complications.

Despite the confounding effects introduced by multiple risk factors, the group under intensive diabetes management had fewer coronary and peripheral vascular events than the controls. When all cardiovascular and peripheral vascular events were combined, intensive therapy reduced the risk of macrovascular disease by 41%. When the study ended, this trend was approaching, but had not yet reached, statistical significance. The ADA noted, "[It] is reasonable to suppose

that better [glycemic] control might slow macrovascular in addition to microvascular complications."[2]

HOW INTENSE DOES "INTENSIVE" HAVE TO BE?

What are the magic glucose numbers? Strictly speaking, there are none. The DCCT proved that the risk of long-term complications is lower in people with IDDM who had more ambitious glucose targets than in those with less ambitious targets. The trial wasn't designed to compare risks at specific levels of *actually achieved* control.

That's not to say that the goals weren't specific. The targets of intensive therapy were

- fasting and premeal blood glucose levels 70–120 mg/dL;
- postprandial glucose <180 mg/dL;
- 3:00 a.m. blood glucose (monitored weekly) >65 mg/dL;
- glycosylated hemoglobin (HbA_{1c}) levels as close to normal as possible ("normal" being ≤6.05% in the assay used by the DCCT).

When the DCCT investigators analyzed the findings by plotting average glycosylated hemoglobin levels against the risk of sustained retinopathy progression, the relation proved remarkably straightforward: The lower the mean glycosylated hemoglobin levels, the lower the risk for retinopathy. That result strongly suggests that *any* improvement in blood glucose control is likely to lower the risk of complications to some degree.

MEETING THE STANDARDS OF CARE

The American Diabetes Association has published standards of care for people with diabetes.[3] *If you treat diabetes, you should document your adherence to these standards,* regardless of the specific glycemic targets you and your patients set. A sample checklist of these recommendations appears on page 13.

UPGRADING DIABETES THERAPY

IDDM: BASIC GUIDELINES

The management of diabetes with intensive insulin regimens requires substantial resources and expertise. If your practice is not geared for this kind of treatment approach, it may be preferable to refer IDDM patients to an endocrinologist or diabetes center. At a minimum:

- Every patient with IDDM should take at least two insulin injections a day. If they are taking only two, these should contain a mixture of short- and intermediate-acting insulin. Such a regimen may achieve adequate glycemic control in individuals who eat and exercise on very regular schedules. **However, three or more injections a day or use of an insulin pump should be recommended, unless clearly contraindicated.**
- Every patient with IDDM (or parent of young children with IDDM) should measure blood glucose at least before each injection. They should be taught how to adjust premeal dosages of short-acting insulin on the basis of SMBG results, calorie intake, and physical activity.
- *No patient with IDDM should adjust insulin on the basis of urine glucose tests alone.* Urine tests for ketones, however, should be performed during

TOOLS FOR INTENSIFYING CONTROL

Why has the 50-year debate over blood glucose control and long-term complications been resolved only now? Because the tools for attempting truly tight control have only been in existence since the late 1970s. The key advances, in addition to new drugs and insulin-delivery systems, were two new ways to monitor the effects of diabetes therapy:

- **Self-monitoring of blood glucose (SMBG).** Finger-prick blood glucose tests enable patients to determine their blood glucose level immediately, anywhere. For patients on advanced insulin regimens, SMBG allows precise premeal dosage adjustments. For anyone with diabetes, it can help monitor the effectiveness of treatment and serve as a motivational tool.
- **Glycosylated hemoglobin testing** (also known as glycohemoglobin, glycated hemoglobin, HbA_1, or HbA_{1c} testing). This laboratory test measures the level of glucose-altered (glycosylated) hemoglobin that has accumulated in the blood over the preceding 2–3 months. It's an indispensable gauge of a person's overall level of diabetes control. (**Note:** Different laboratories use slightly different scales for their glycosylated hemoglobin results—blood from a normal volunteer might read 6% at one lab and 7% at another. So know the reference values for the lab you use.)

Patients with IDDM should be taught how to adjust premeal dosages of short-acting insulin on the basis of blood glucose test results, calorie intake, and physical activity.

periods of illness or stress, or whenever blood glucose rises above 240 mg/dL.

- Every patient with IDDM should carry some form of simple carbohydrate (eg, glucose tablets) to counteract hypoglycemia. Family members (and, ideally, co-workers or school personnel) should know how to administer glucagon in the event of severe hypoglycemia.
- Every patient with IDDM should have 24-hour access to a health professional knowledgeable about diabetes.
- Every patient with IDDM should receive education from professionals who can help develop and monitor a diabetes management program; this should include an eating plan, exercise plan, and training on such topics as managing diabetes during sick days and when traveling.

According to the DCCT researchers, IDDM patients for whom intensive diabetes therapy *may not* be appropriate include

- patients who experience frequent severe hypoglycemia or who do not experience the typical early warning signs of hypoglycemia (eg, sweating, trembling);
- patients whose diabetic complications, particularly renal disease, are already far advanced;
- patients with coronary or cerebrovascular disease (whose conditions may be worsened by frequent or severe hypoglycemia);
- children under 13 years. (The DCCT didn't study anyone younger. According to the ADA, tight control is contraindicated in children under 2 years, and should be attempted with extreme caution in those under 7 years.)[2]

NIDDM: A Stepped-Care Approach

The chart running across the centerfold is a simplified guideline for upgrading diabetes therapy in people with NIDDM. It is generalized and does not apply to all patients and situations. The glucose values defining "unacceptable," "better," and "best" are broad estimates, based on typical blood glucose tests. The accompanying glycosylated hemoglobin values are a somewhat more reliable guide.

Key points

- *Resource inventory.* Before intensifying a patient's therapy—indeed, before treating diabetes at all—you should take stock of the resources and knowledge needed to apply the regimen successfully. If they are not available, it may be preferable to refer the patient to a specialist or diabetes treatment program. Resource needs grow cumulatively with more advanced diabetes treatment regimens.
- *Go for the green.* The object is to improve blood glucose control from the red "unacceptable" zone (BG >200 mg/dL; HbA_{1c} >10%) to the green "best" zone (BG <140 mg/dL; HbA_{1c} 6–8%), where the best chances of preventing complications reside.
- *The middle ground.* The yellow ("better") zone corresponds roughly to conventional control in the DCCT. At this level of control, a patient will likely feel well most of the time. But the risk of complications is significantly higher than that for patients in the "best" zone.
- *Document discussions.* There may be sound reasons why you

and your patient decide that "better" is good enough. But in light of the DCCT, make sure your patient understands that lower blood glucose levels will likely decrease the risk of complications, and document that discussion. Patients who develop complications in the future will have reason to ask whether their doctors took aggressive enough steps to move them from "better" to "best." You should also advise the patient of the increased risk of hypoglycemia if a decision is made to intensify therapy.

STEP 1: DIET AND EXERCISE

Resource inventory

- Education capability for meal planning, exercise counseling, and (if required) weight loss
- Diabetes education capability (nurse/educator if possible)
- Minimum testing:
  —Glycosylated hemoglobin
  —Lipid profile
  —Microalbuminuria, serum creatinine
  —ECG, BP

For an individual newly diagnosed with NIDDM and without acute symptoms of diabetes, the first-line therapy is a diet and (if not medically contraindicated) exercise plan. In some patients, these measures may be all that's needed to control diabetes adequately, although about 85% of NIDDM patients do eventually require medication. Even then, diet remains essential. In fact, dietary backsliding is at the root of many medication "failures."

Dietary goals. For obese NIDDM patients—the majority—the primary dietary goal is weight loss. When patients lose weight, their tissues become more sensitive to insulin and thus remove more glucose from the blood; weight loss also reduces glucose production in the liver.

In addition to calorie restriction, dietary goals include

- distributing calories as evenly as possible throughout the day, to avoid large after-meal glucose "excursions";
- maintaining a balanced diet, with about 50–60% of calories from carbohydrates (especially high-fiber foods), no more than 30% of calories from fat, and the balance from protein. In other words, a basic "heart healthy" diet;
- moderation in sugar and alcohol consumption. For most patients, strict prohibition of either is no longer considered necessary. Sugar taken as part of a balanced meal should not raise blood glucose dramatically.

If you have the expertise and the time, you can sit down with the patient, explain how food affects diabetes control, and help him or her develop a sensible and palatable meal plan. But weight loss is difficult, and you will probably need to enlist the aid of a registered dietitian or refer your patient to a local, reputable weight-loss program.

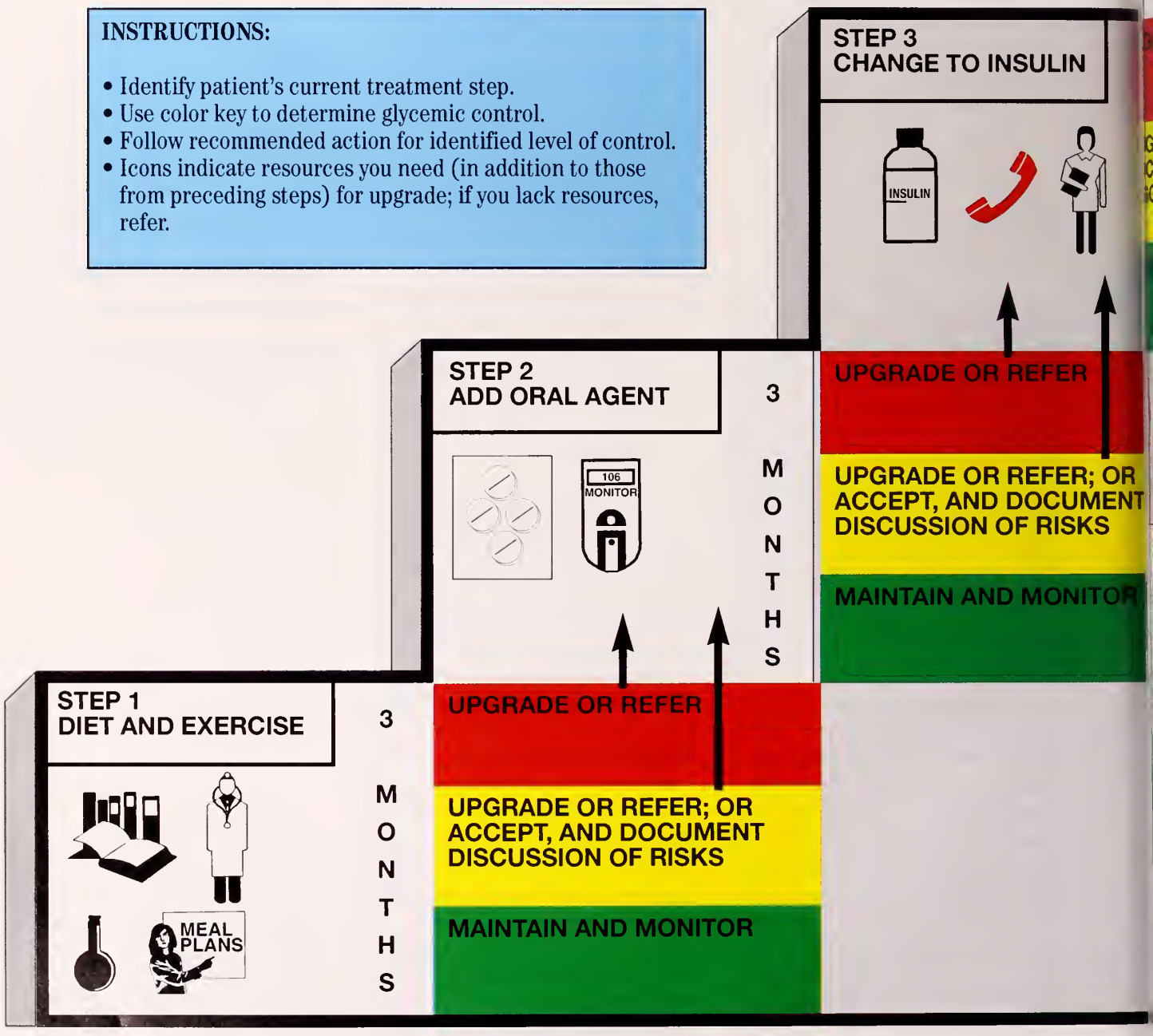
Exercise. Physical activity (specifically, aerobic exercise, as opposed to resistance training) lowers blood sugar acutely. Aerobic conditioning also increases the body's overall sensitivity to its own insulin, aids weight loss, and has a favorable impact on serum lipids. If a patient is new to exercise and over age 35, an exercise tolerance test is recommended to make sure

About 85% of NIDDM patients eventually require medication. Even then, diet remains essential.

UPGRADING GLYCEMIC CONTROL IN NIDDM: A STEPPED–CARE APPROACH

INSTRUCTIONS:

- Identify patient's current treatment step.
- Use color key to determine glycemic control.
- Follow recommended action for identified level of control.
- Icons indicate resources you need (in addition to those from preceding steps) for upgrade; if you lack resources, refer.



TP 4
ITNSIVE INSULIN
HIRAPY

24 hours

3 MONTHS

REFER!

REFER; OR ACCEPT, AND DOCUMENT DISCUSSION OF RISKS

MAINTAIN AND MONITOR

GRADE OR REFER

GRADE OR REFER; OR CEPT, AND DOCUMENT CUSSION OF RISKS

INTAIN AND MONITOR

COLOR KEY

UNACCEPTABLE

BG >200 mg/dL; HbA_{1c} >10%

BETTER

BG 140–200 mg/dL; HbA_{1c} 8–10%

BEST

BG <140 mg/dL; HbA_{1c} 6–8%

RESOURCE KEY

Physician

Nurse/educator

Diabetes education

Lab tests

Dietitian

Blood–glucose monitoring

Oral hypoglycemic agents

Insulin

Hotline access

Psychological counseling

there is no underlying vascular disease. If an examination yields no reason to avoid exercise, recommend it. If the patient has no idea how to begin, you can have phone numbers of local exercise programs ready or suggest a trip to an exercise physiologist for help in developing a personalized program. If the patient has significant vascular disease, an exercise program should not be recommended until an appropriate medical evaluation has been completed.

Monitoring. If you treat diabetes, you must become familiar with glycosylated hemoglobin testing. When you are instituting or changing therapy, a baseline glycosylated hemoglobin test, followed by another in a few months, is an excellent way to see whether the patient's glycemic control has actually improved. This laboratory test should be performed *at least twice a year in all people with diabetes,* according to standards of diabetes care developed by the American Diabetes Association.[3]

Glycosylated hemoglobin testing should be performed at least twice a year in all people with diabetes.

If diet and exercise alone achieve acceptable control, glycosylated hemoglobin testing during periodic checkups may be all the glucose monitoring needed. However, all patients should be encouraged to learn SMBG and use it regularly to determine how their treatment plan is working.

Monitoring for complications. Monitoring your patient for signs of long-term complications is also essential from the very start. Because NIDDM often goes undiagnosed for years, it's not unusual to discover signs of complications at the time diabetes is diagnosed. One fairly new resource in this regard is microalbuminuria testing—a way of detecting minute quantities of urinary protein. Even if a standard urine dipstick test turns up negative for protein, microalbuminuria could indicate early signs of diabetic kidney disease, a strong argument for intensive glucose control. Vigorous control of hypertension, if present, has also been shown to help slow the progression of nephropathy. Also, all people with diabetes who are older than 30 years or have had diabetes for at least 5 years should have yearly ophthalmic exams.

STEP 2: ADD ORAL HYPOGLYCEMIC AGENT

Resource inventory

- Resources as for Step 1
- Oral agent selection rationales
- Education on dosage, timing, adverse drug interactions, and hypoglycemia
- SMBG training

If, after a 3–month trial of diet and exercise, the regimen does not bring blood glucose concentrations into an acceptable range, or if it achieves "better" control when "best" is the agreed-upon goal, adding an oral hypoglycemic agent (OHA) is usually the next step. Like all clinical judgments, this is not an ironclad rule. Many physicians would consider insulin the first-line drug in some patients, eg, young, lean individuals with NIDDM.

A common side effect of sulfonylureas is hypoglycemia. Because research and clinical experience show that many patients cannot sense hypoglycemia correctly—and may treat for it when their blood glucose levels are in a normal range—those on OHAs also need to be trained in SMBG. SMBG can help document the effectiveness of treatment, confirm hypoglycemic episodes, and aid in recognition of high blood glucose levels caused by mistaken or excessive treatment for hypoglycemia.

Neither doctor nor patient should be lulled into thinking that an OHA, or insulin for that matter, is a license to abandon diet and exercise.

STEP 3: CHANGE TO INSULIN

Resource inventory

- Resources as for Steps 1 and 2
- Nurse/educator availability for education on insulin dosage, timing, injection techniques, hyper-, and hypoglycemia
- Dietitian availability for coordinating meal plan with insulin injections.
- HbA_{1c} testing 2–4 times a year
- Physician accessibility during dosage adjustment periods

If OHAs at the maximum recommended dosage do not bring blood glucose concentrations out of the unacceptable range within 3 months, if they achieve "better" control when you and your patient have agreed your goal is "best," or if they work for a time and then lose their effectiveness, the next step is insulin. Within the first year of use, OHAs prove insufficient in about 30% of patients; they lose effectiveness in 5 to 10% of users each year after that.

The framework of these simplified guidelines incorporates four sequential steps: 1) diet and exercise, 2) addition of OHAs, 3) change to insulin, and 4) intensive insulin therapy. In some cases, physicians have found that they could achieve more normal blood glucose concentrations and extend the period of OHA use by adding an injection of intermediate-acting insulin at bedtime.

Note that NIDDM does not become IDDM just because a patient switches to insulin. The patient simply becomes an insulin-requiring person with non–insulin-dependent diabetes.

In NIDDM, unlike IDDM, a regimen of two daily insulin injections stands a reasonable chance of achieving adequate—in some patients even excellent—glycemic control. Such success is most likely when NIDDM is of recent onset with relatively mild hyperglycemia.

A reasonable initial dose of insulin is 0.25 units per pound of body weight per day. Common two-injection insulin regimens, in order of increasing complexity, include

- Two injections of intermediate-acting insulin, two-thirds before breakfast and one-third before supper;
- Two injections of premixed insulin (eg, 70% NPH, 30% regular), two-thirds before breakfast and one-third before supper;
- Two injections of mixed short- and intermediate-acting insulin, where the dosage of the short-acting insulin is adjusted according to premeal SMBG test results and the anticipated size of the meal.

STEP 4: INTENSIVE INSULIN THERAPY

Resource inventory

- Resources as for Steps 1–3
- 24-hr hotline
- SMBG ≥4 times daily
- Nurse/educator availability for intensive training on hypoglycemia (awareness, prevention, treatment) and for advanced insulin dosage adjustment training
- Availability of professional help for emotional and motivational counseling

NIDDM does not become IDDM just because a patient switches to insulin. The patient simply becomes an insulin-requiring person with non–insulin-dependent diabetes.

Intensive insulin regimens are not common therapy for NIDDM but may be necessary in patients who develop severe insulin deficiency in addition to insulin resistance.

If two injections per day, even in a split/mixed regimen, do not bring blood glucose concentrations into an acceptable range, or if they achieve "better" when you want "best," the last option is multiple-injection or insulin pump therapy: the "intensive" regimens used in the DCCT. These are not common regimens for treating NIDDM but may be necessary in patients who develop severe insulin deficiency in addition to insulin resistance. They require experienced and available health professionals, and a dedicated, motivated patient.

Typical multiple-injection regimens include

- Three SMBG-adjusted premeal injections of regular insulin, with intermediate-acting insulin mixed in at supper, to cover glycemia overnight;
- Three-injection regimen consisting of 1) a prebreakfast injection of intermediate- and short-acting insulin, 2) a presupper injection of short-acting insulin, and 3) a bedtime injection of intermediate-acting insulin to last all night;
- Three SMBG-adjusted premeal injections of regular insulin plus an injection of long- or intermediate-acting insulin at bedtime.

Insulin pumps, preferred by some patients, are computerized, motor-driven syringes that deliver insulin to a subcutaneous catheter. The pump, which contains short-acting insulin only, delivers a small amount constantly (the basal delivery) and allows the patient to adjust premeal doses (boluses) on the basis of SMBG results.

Unless you are already part of a team that includes, at a minimum, a diabetes nurse/educator, dietitian, and mental health professional, and unless a knowledgeable team member is available to answer questions 24 hours a day, it's best to leave these intensive regimens to diabetes specialists.

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PATIENT NAME _____

CLINICAL PRACTICE RECOMMENDATIONS FOR DIABETES MELLITUS

This guideline indicates minimum standards of continuing care for stabilizing patients with diabetes; it is not intended to preclude more extensive evaluation and management. A comprehensive medical history should be taken at the initial visit to confirm the diagnosis, review previous treatment, evaluate glycemic control and complications status, and provide a basis for continuing care. Any abnormal findings on physical examination should be re-evaluated at subsequent visits.

Indicate that a task was performed by initialing box. Shaded boxes are optional tasks.

VISIT	Initial	3 mo.	6 mo.	9 mo.	Annual	3 mo.	6 mo.	9 mo.	Annual
DATE									
PHYSICAL:									
Complete history and physical, including height									
Weight									
Blood pressure									
Ophthalmoscopic exam									
Foot exam									
Interim history and physical									
LABORATORY:									
HbA_{1c}									
Fasting plasma glucose		*	*	*		*	*	*	
Lipid profile									
Urinalysis ✓†									
Urinary microalbumin									
Serum creatinine									
ECG†									
OTHER:									

DOCUMENT GOALS AND MANAGEMENT PLAN									
REFERRAL TO OPHTHALMOLOGIST									

Adapted from *Diabetes Care*, 1994;17(6)616.

ICD-9 CODES:
250.___0 NIDDM, not stated as uncontrolled
250.___2 NIDDM, uncontrolled
250.___1 IDDM, not stated as uncontrolled
250.___3 NIDDM, uncontrolled
250.___ Indicates complication and type of diabetes

* may be useful
✓ annual retest recommended if abnormal
† many clinicians routinely test annually

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Good News About Your Diabetes

Scientists have just proved that controlling blood sugar *carefully* can help prevent the long-term complications of diabetes.

A study called the Diabetes Control and Complications Trial (DCCT) compared two groups of people with diabetes:

- Those who controlled their blood sugar well enough to avoid extremes of high and low blood sugar and to feel well most of the time.
- Those who worked closely with doctors, nurses, and others to keep their blood sugar as near to normal as possible.

IT REALLY WORKED!

The extra effort paid off! People who worked harder to keep the amount of sugar in their blood near normal had fewer signs of diabetic eye, kidney, and nerve disease at the end of the 6 1/2-year study. These long-term problems were reduced by more than half. Keeping blood sugar as close to normal as possible also tended to lower the risk of heart disease and poor leg circulation.

WHO CAN BE HELPED?

The study was done only in people taking insulin, but experts agree that all people with diabetes—whether they're treated with diet or pills or insulin—can lower their risk of complications by improving their blood sugar control.

THE TRADE-OFF

But when you aim for normal blood sugar levels, you increase the chances of overshooting the target and lowering sugar levels too far. This is true mainly if you take insulin, but it can also occur if you take diabetes pills. In the DCCT, the group working toward normal blood sugar had three times more low blood sugar reactions than the other group. You can learn to watch out for these reactions and prevent or correct them, but they can be dangerous if not treated quickly and properly.

One other downside: if you take insulin several times a day, controlling blood sugar more tightly can cause some weight gain because insulin helps your body store calories better.

WHAT TO DO?

Ask your doctor about the DCCT and whether a change in treatment makes sense for you. Changing your treatment plan today could make a big difference to your health in the future.

WHAT ELSE IS NEW?

Diabetes experts recently spelled out the basic steps that all health professionals should follow for people with diabetes.

Whenever you visit your doctor or clinic, expect to discuss:

- how well your treatment plan is working
- the target glucose levels you're aiming for
- your blood glucose self-monitoring results
- any high or low blood glucose results
- your medications
- any changes in your routine

And you should have these checked:

- your weight
- your blood pressure
- your blood glucose
- your feet and eyes

You should also have a *glycosylated hemoglobin* test: it provides a snapshot of how well your blood glucose was controlled over the last 2–3 months.

BETWEEN VISITS

Write down your test results and make notes about things you want to talk about.

EVERY YEAR

You should have these tests:

- cholesterol
- triglycerides
- an electrocardiogram (heart test)
- kidney function
  —creatinine in blood
  —protein in urine
- a complete eye exam by an eye doctor

ASK QUESTIONS

And remember: the most important person on your healthcare team is **you**!!

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Supplement to advertising insert

A primary care perspective on "Upgrading Diabetes Therapy" and NIDDM

Dean R. Keller, MD, Madison

Diabetes mellitus is the most prevalent endocrine disorder in primary care. Most outpatient diabetic visits (> 90%) are to primary care physicians. The large majority of these patients are NIDDM (type 2), it is estimated that 6.5 million people in the United States have a diagnosis of NIDDM and that another 6 million are currently undiagnosed and developing complications. Clearly, as primary care physicians, we are providing the majority of care to type 2 diabetics. Primary care practices probably vary widely in how often we check hemoglobin A1C's, do foot examinationss, or check for microalbuminuria. We all strive to give our diabetic patients the best care we can, and articles such as "Upgrading Diabetes Therapy" raise issues which may help us to do just that.

The following article should be relevant and applicable to primary care diabetic management, it illustrates a stepped care approach with the "resource inventory" needed for each step. While most of us treat diabetes in a stepped care manner, this article points out considerations and timing for each individual step, as well as a visual reminder chart included on pages 8 and 9. Also, the "Clinical Practice Recommendations for Diabetes Mellitus" on page 13 could be useful as a rough guideline and tailored to each primary care practice. Of note, in the "Resource Inventory" is the multidisciplinary approach using dieticians, nurse diabetic educators, and professional help for emotional and motivational counseling. Managed care settings, shared practices and most communities have access to these professionals--the article stresses the importance of using them.

It is worthwhile looking closely at each "step" in the article. Step 1 emphasizes weight loss, exercise, checking a hemoglobin A1C twice a year (at least), and monitoring early for complications. I think most of us would agree with this initial step and also agree based on our own experience with the article's comment that 85% of these patients will eventually require medications. Monitoring for microalbuminuria and vigorous control of hypertension are also worthwhile. Under Step 2, the three-month period of diet and exercise is made clear, and although the use of an oral hypoglycemic is usually next, consideration for insulin at this time is also pointed out. Self-monitoring of blood glucose is also in Step 2, however, not all insurance carriers will cover glucose monitoring on oral agents and it can be expensive. Nevertheless, it is the best mechanism to see if the patient is achieving adequate glucose control in a timely manner. Step 3 involves insulin use for better glucose control, emphasizing the important concept that diabetes mellitus therapy is not a static process. Also important to note is the reasonable chance of achieving control with relatively simple insulin regimens. Step 4 which is using multiple insulin injections or insulin pump therapy and "best left to the diabetic specialist" is uncommon in NIDDM and reinforces the important role of the primary care physician inNIDDM. The use of a specialist certainly does not need to be isolated to Step 4. If satisfactory control is not achieved in a reasonable amount of time, if assistance is required in using newer oral agents such as Metformin, or a brief period

Continued on next page

Dr Keller is an assistant professor of medicine with the Section of General Internal Medicine at the University of Wisconsin-Madison. This commentary was supported by Novo Nordisk Pharmaceuticals, Inc.

Continued from preceding page
of intensive education and support is needed, the diabetologist could be involved at any step.

The article "Upgrading Diabetes Therapy" begins with the DCCT study and its important results of decreasing retinopathy, neuropathy and nephropathy with "intensive" insulin therapy. This study done in type 1 diabetics also had an increased risk for hypoglycemia and some weight gain. Can we extrapolate this "tight control" to the more prevalent NIDDM? The risk-to-benefit ratio of intensive control is probably less certain in type 2 diabetes. While hypoglycemia is thought to be less common in NIDDM, patients with coronary artery disease or cerebrovascular ischemia do not tolerate hypoglycemia well. What effect tight control has on macrovascular complications and those with already advanced microvascular complications is not entirely worked out as prospective tight control studies for NIDDM are lacking.

From the primary care perspective, documenting a treatment plan, being aware of the standards reviewed in the article, and realizing that decreasing hyperglycemia may help to slow the presentation and progression of complications in NIDDM are all useful concepts for primary care diabetic management.

Acknowledgements
Russell M. Dixon, MD, MS, for suggestions and review of this editorial. Dr Dixon is associate professor of medicine with the Section of Endocrinology at the University of Wisconsin-Madison and is a past president and current board member of the American Diabetes Association Wisconsin Affiliate.

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Department of Revenue targets physicians for audits

THE WISCONSIN DEPARTMENT of Revenue (DOR) has initiated a pilot program that targets physicians' collections of sales and use tax. Currently, only physicians from certain counties in eastern Wisconsin such as Racine, Milwaukee and Waukesha counties are being audited. This program will continue throughout 1995 and, once "fine-tuned," will expand to physicians outside the target areas. In past years, other professions such as attorneys and accountants have been the focus of similar audits.

According to a preliminary draft of information which will be provided to audited physicians, the DOR considers sales of medical services a non-taxable event and exempt from the sales tax requirement. "Medical Services" is defined as services performed on a human being in the diagnosis, cure, mitigation, treatment or prevention of disease. Thus, physical exams, surgery, immunizations are not taxable events. The sale of "tangible personal property" is considered taxable. Physicians must collect a sales tax on these items when they are provided to a patient. Failure to collect sales tax on these items will result in a tax deficiency. Examples of items the DOR considers taxable "tangible personal property" include:

- non-prescription items such as vitamins and non-prescription medicines;
- photocopies of medical records when the physician has charged for photocopying; and
- parking charges to employees, clients and others.

An exception to the above is if an item is transferred "incidentally" to the patient while providing medical services. Transfer of these types of items are not a sale subject to Wisconsin sales or use tax. "Incidentally" means that the true objective of the patient is to obtain medical service rather than the tangible personal property that is transferred.

An example of an incidental transfer is the application of a cast during the treatment of a broken arm. Physicians are also required to pay a use tax on items purchased where the Wisconsin sales tax was not charged to the physician at the time of sale, mostly items purchased thorough mail-orders including shipping and handling charges. In past audits, the DOR has collected $315,000 in back taxes on out-of state purchases from Wisconsin attorneys, $400,000 from professional tax preparers and $200,000 from certified public accountants.

If providers cooperate, no penalty is currently being assessed for failure to collect sales tax. The uncollected tax, however, will be assessed against the physician or office, as well as late filing fees and interest. SMS suggests physicians contact their accountants to verify adherence with sales tax requirements. Questions can be directed to the Department of Revenue, P.O. Box 8902, Madison, WI 53708-8902, (608) 266-2772 or to Craig Johnson at (608) 266-7166.❖

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Nurse prescribers required to carry own malpractice insurance

Wisconsin Act 138 giving advance practice nurses prescription-writing privileges, effective April 1, requires that APNPs have their own malpractice liability coverage. PIC Wisconsin will offer separate coverage ($400,000/$1 million) to APNPs as an endorsement to a currently insured physician, clinic, group or hospital. PIC Wisconsin will not offer a stand-alone policy.

If you employ or supervise a qualified APNP, contact your SMS Insurance Services agent or Alice Ballweg directly at 1-800-545-0631 or (608) 283-5483.❖

Date of Report: ___/___/___
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RETURN TO WORK/PHYSICAL CAPABILITIES REPORT

Employee Name: _____ Date of Birth: ___/___/___

Employer Name: _____ Position: _____

Employer Address: _____ Date of Injury: ___/___/___

TO BE COMPLETED BY ATTENDING PHYSICIAN

Relevant Diagnosis: 1. _____
2. _____
3. _____

Condition: ☐ Improved ☐ Unchanged ☐ Stable ☐ Symptoms Worse ☐ NA **Work Related:** ☐ Yes ☐ No ☐ ?

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Work level (lift/carry)		Per work shift	
Sedentary (Sed)	0 - 10 lbs.	Never (Nvr)	0%
Light	10 lbs. freq. - 20 lbs. max	Seldom	1 - 10%
Light - Medium	20 lbs. freq. - 35 lbs. max	Occasionally	11 - 30%
Medium (Med)	20 lbs. freq. - 50 lbs. max	Frequently	34 - 66%
Heavy	50 lbs. freq. - 100 lbs. max	Continually	67 - 100%

WORK AND OFF WORK CAPABILITIES

☐ Stitches/Butterflies ☐ Prescription Meds

☐ 1. Employee should be able to return to previous work without restrictions on ___/___/___.
☐ 2. Employee is totally disabled,
☐ 3. Employee should be able to return to work on ___/___/___ subject to following restrictions; until ___/___/___. ☐ Permanent
☐ 4. Medications prescribed may affect work performance.

Work level ☐ sed ☐ light ☐ light/med ☐ medium ☐ heavy
Hours/day _____
Days/week _____
Days overtime/week _____

May sit _____ hrs at a time
May walk _____ hrs at a time
May stand _____ hrs at a time
Should change positions every _____ hour/s
May only work between _____ and _____ levels
Not work more than _____ inches from body

May Bend: ☐ ☐ ☐ ☐ ☐

Bend:	☐ Nvr	☐ Seldom	☐ Occas.	☐ Freq.	☐ Cont.
Squat:	☐ Nvr	☐ Seldom	☐ Occas.	☐ Freq.	☐ Cont.
Climb:	☐ Nvr	☐ Seldom	☐ Occas.	☐ Freq.	☐ Cont.
Crawl:	☐ Nvr	☐ Seldom	☐ Occas.	☐ Freq.	☐ Cont.
Twist:	☐ Nvr	☐ Seldom	☐ Occas.	☐ Freq.	☐ Cont.

Boxes not marked indicate no restriction

***SPECIFY - RIGHT, LEFT or BILATERAL (Circle R-L-BIL)**

Grasp:	☐ Nvr	☐ Seldom	☐ Occas.	☐ Freq.	☐ Cont.	R - L - BIL
Pinch:	☐ Nvr	☐ Seldom	☐ Occas.	☐ Freq.	☐ Cont.	R - L - BIL
Twist (wrist):	☐ Nvr	☐ Seldom	☐ Occas.	☐ Freq.	☐ Cont.	R - L - BIL
Push/Pull wih hands	☐ Nvr	☐ Seldom	☐ Occas.	☐ Freq.	☐ Cont.	R - L - BIL
Fine finger manipulaton:	☐ Nvr	☐ Seldom	☐ Occas.	☐ Freq.	☐ Cont.	R - L - BIL
Wrist flextion/extension:	☐ Nvr	☐ Seldom	☐ Occas.	☐ Freq.	☐ Cont.	R - L - BIL
May use feet for repetitive movements:	☐ Nvr	☐ Seldom	☐ Occas.	☐ Freq.	☐ Cont.	R - L - BIL
Exposure to unprotected heights:	☐ Nvr	☐ Seldom	☐ Occas.	☐ Freq.	☐ Cont.	R - L - BIL
Exposure to moving machinery:	☐ Nvr	☐ Seldom	☐ Occas.	☐ Freq.	☐ Cont.	R - L - BIL

I saw this patient on ___/___/___. Patient discharged: ☐ Yes ☐ No Patient to be seen again for re-evaluation on ___/___/___.
Other Comments/Recommendations: Referred to: _____

Physician's written signature: (no stamps) Date:

Physician's Printed or Stamped Name/Address/City/State: Phone:

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize my attending physician and/or hospital to release any information or copies thereof acquired in the course of my examination or treatment for the injury identified above to my employer or employer's representative.
Patient's Signature: **Date:** ___/___/___

*this is just a physician's estimate of the patient's ability to perform the task.

SMSH(11/94)

Lawmakers give final passage to SMS tort reforms

After many years of making the case for medical liability reforms to the Legislature, Wisconsin physicians have achieved a long-awaited victory. The state Assembly gave final approval to Assembly Bill 36, the State Medical Society's tort reform vehicle. Authored by state Rep Mark Green (R-Green Bay) and Sen Joanne Huelsman (R-Waukesha), and co-authored by Rep Sheryl Albers (R-Loganville) and Rep Joseph Handrick (R-Minocqua), AB 36 provides for a $350,000 cap on noneconomic damages in medical liability cases, application of the $150,000 cap on noneconomic damages to medical liability cases, modification of the collateral source rule, and periodic payment of future medical expenses exceeding $100,000. The bill passed with bipartisan support in both houses of the Legislature.

"Wisconsin physicians made a compelling case for the reforms contained in AB 36," said SMS Immediate Past President Richard G. Roberts, MD, JD. "This success is the result of hundreds of telephone calls and letters to members of the Legislature over the last 10 years, as well as heartfelt testimony at public hearings on the issue of medical liability reform held by the Legislature. Wisconsin physicians are personally responsible for this long-overdue accomplishment."

Dr Roberts had praise for the bill's authors and co-authors, as well as legislators who helped make victory possible. "Physicians across the state are grateful for Speaker David Prosser's commitment to medical liability reform. He made good on a promise to bring this issue to the forefront if the Republicans took control of the Assembly." Roberts also noted the individual efforts of Representatives Frank Urban, M.D. (R-Brookfield), Sheldon Wasserman, M.D. (D-Milwaukee), and Mark Meyer (D-La Crosse) and State Senators Mike Ellis (R-Neenah), Peggy Rosenzweig (R-Wauwatosa), Alberta Darling (R-River Hills), and Joe Andrea (D-Kenosha) as critical to passage of the bill.

AB 36 has been forwarded to Governor Thompson's desk. The governor is expected to sign the bill in the near future, thus making it the law of Wisconsin.❖

Milwaukee oncologist is installed as new SMS president

Marcia J.S. Richards, MD, a board-certified radiation oncologist from Milwaukee, was sworn in as the new SMS president April 8 in Lake Geneva. Dr Richards will focus her term as president on helping Wisconsin residents cope with changes in the state's health care delivery system due to an increase in managed care.

Dr Richards is in private practice in Milwaukee where she is medical director of the section of radiation oncology at St. Lukes Medical Center. She is also president of Radiation Oncology Associates, S.C., a 12-person radiation oncology group with three practice bases—Milwaukee, Green Bay and Racine-Kenosha. She graduated from the University of Wisconsin Medical School in 1970, completed an internship in pediatrics at University of Wisconsin Hospitals-Madison, and then did a fellowship in radiation oncology at the same institution.

Dr Richards has served on the SMS Board of Directors since 1988. She was president of the Medical Society of Milwaukee County in 1990-1991 and has served as an

Continued on next page

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MSMC board member since 1986. She has served on the board of directors for the Foundation for Medical Care Evaluation (1982); American Cancer Society Wisconsin Division, serving as ACS president in 1993-1994; and the Wisconsin Radiological Society (1989-present), where she currently serves as vice president. She is also past president of the Wisconsin Society of Radiation Oncologists (1981-1983) and current board member for PIC Wisconsin.

The new SMS president has been an advocate for education of women on the subject of breast cancer, serving as chair of the Breast Cancer Detection and Awareness Project and speaking to local, state and national organizations on breast cancer.❖

SMS elects new slate of officers; Dr Ulmer elected president elect

THE SMS HOUSE of Delegates, at its annual meeting April 8, elected the following slate of officers: president elect for 1995-96--Richard H. Ulmer, MD, of Marshfield; treasurer for 1995-96--Harry J. Zemel, MD, of Fond du Lac; and speaker of the House of Delegates for 1995-97--Sandra L. Osborn, MD, of Verona. The House also elected the following AMA delegates: John D. Riesch, MD, of Menomonee Falls (1996-97); Kenneth M. Viste, Jr., MD, of Oshkosh (1996-97); Susan L. Turney, MD, of Marshfield (1995-97). Elected as alternate delegates to the AMA were: Kevin T. Flaherty, MD, of Wausau (1996-97); Robert J. Jaeger, MD, of Stevens Point (1995-97); and Paul J. Leehey, III, MD, of La Crosse (1995-97). Elected at the April 9 Board of Directors meeting were Raymond Zastrow, MD, of Milwaukee, as chair and Mark Andrew, MD, of Virocqua, as vice chair.❖

YPS accepts new members, elects officers

THE YOUNG Physician's Section events at the recent SMS Annual meeting were very successful with the group adding several new physicians to its active ranks. Young physicians were well represented both on the House floor and in reference committees.

In addition, the YPS viewed a final draft of a possible new program it will be sponsoring called the New Physician Ambassador Program.

The 1995-1996 elected officers of the section are: chair--Kathleen Wick, M.D.; chair-elect--Adam Balin, M.D.; AMA delegates Scott Beede, M.D., and Evan Saunders, M.D. The YPS meets approximately four times during the year by telephone conference and twice in person for dinner meetings. Questions? Call Anne Rittman at the SMS, at 1-800-362-9080 (outside Madison) or 257-6781 (in Madison). ❖

Dr Mike Armstrong to chair Resident Physicians Section

THE RESIDENT Physicians Section (RPS) of the State Medical Society met during the SMS annual meeting to hold its annual Resident Section luncheon and business meeting and elect officers for 1995-1996.

Newly elected officers of the section are: chair--Michael Armstrong, MD, vice chair--Charles Rainey, MD, editor--Patricia Hanstch, MD, and members-at-large--Michael D'Amico, MD, and Kenneth Buley, MD At the meeting, the RPS received a national legislative update from Steve Ellwing, director of AMA Resident Physician Services. Interested in joining? Call Anne Rittman, 1-800-362-9080.❖

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1994 Mini-internship report

Paul M. Fleming, MD, Sheboygan

The Sheboygan County Medical Society's mini-internship program was presented and discussed at a county medical society meeting in March 1994. Those present expressed interest in starting such a program.

I developed a questionnaire and distributed it to all medical society physicians on April 4, 1994. In it, I inquired whether society members thought we should put on a mini-internship program. I also asked whether the physician was interested in participating as a faculty member or as a member of the organizational committee. Ninety responses were obtained. Of these, 72 approved a mini-internship, and 18 said no. Included in the 72 were 42 who volunteered to serve.

I formed a committee of eight physicians consisting of those who had expressed an interest in the organization of the program. Our first meeting was May 26, 1994. At that meeting, we set a target date of Oct 16-18, 1994 for the internship itself. We formed a subcommittee to determine appropriate invitees. We planned to send 12 invitations to a variety of community leaders, expecting a positive response from four to six. We also determined that we would involve all three hospitals in Sheboygan County in the planning as well as the hosting of the interns during the internship itself.

Invitations went out on July 5, 1994. Plans began to gel regarding locations of orientation and debriefing sessions, etc. I sent a memo to all physicians who had expressed interest in becoming faculty. The memo updated them on progress in developing the internship program and allowed them an opportunity to withdraw from the faculty if they had any second thoughts. None pulled out.

I went to hospital administrators to solicit help in hosting orientation and debriefing dinners, purchasing lab coats for the interns, and printing name tags. Both hospitals in Sheboygan were very helpful and willing to help wherever they could. The Sheboygan Memorial Medical Center even placed its secretarial staff at my disposal for correspondence regarding the mini-internship.

As responses to the invitations came in, we noted that several of the CEO's who had been invited delegated their human resource and employee benefits directors as interns. In those cases I sent a separate invitation to those individuals.

We ended up with a group of five interns: a county judge, a Sheboygan reporter, and three employee benefits directors.

On Aug 2, 1994, I sent a letter to all five prospective interns welcoming them and giving them a brief overview of the program and the tentative schedule. A confidentiality agreement was also included in the letter. I also sent a letter to each invitee who had declined our invitation.

A subcommittee then set to work matching interns with faculty members. Matches were based on schedules as well as preferences expressed by the interns on their response forms. Three of the interns were scheduled to spend some time in operating rooms. Three were scheduled to spend Monday afternoon in one of the three emergency room in the county.

After matching of interns with faculty had been accomplished, a letter was sent to those faculty involved. It went out Aug 30, 1994. Some schedule juggling was soon to be found necessary as two faculty members found they could not meet the schedule. Ultimately we had 22 faculty members matched with the five interns. We scheduled the interns who were to spend Monday afternoon in an emergency room with a pathologist as well. This was to keep the afternoon interesting if the ER was not busy. Unfortunately this double scheduling was not well received as the physicians felt that not enough time was allotted for each area.

Three weeks before the target day, a reminder letter was sent to interns and faculty. In that letter was an individualized schedule for each participant. A master schedule was also enclosed in the letters to faculty members. This was to help expedite the noon changeovers of interns from one faculty member to the next.

On Sunday evening, Oct 16, 1994, the mini-internship began with an orientation meeting for physicians followed by cocktails and dinner provided by St Nicholas Hospital. At the dinner, each table had an intern with the faculty members with whom he or she would spend the next two days. Lab coats and name tags were placed at each intern's setting. Welcome speeches were given by me and the assistant administrator of St Nicholas Hospital.

This orientation meeting provided each intern with the opportunity to meet and converse with his or her faculty members. Details regarding their schedules were finalized at this time, since by this time each physician knew where his or her Monday would start, what surgical cases were scheduled, etc. Each faculty member had been encouraged to schedule a breakfast or lunch with their intern if possible.

On Monday morning, Oct 17, 1994, the program began. The advance planning seemed to have paid off since the program essentially ran itself. I had made myself available to

sort out problems, but none arose. The morning faculty took responsibility for getting their interns to the offices or hospitals of the afternoon faculty.

On Tuesday, Oct 18, 1994, we were fortunate to have our County Medical Society Continuing Medical Education program reviewed by the State Medical Society for Category I approval. This review included an opportunity for the reviewers to attend a noon medical staff educational meeting. This also afforded us an opportunity to introduce the program as well as its interns to the rest of the medical staff and to the state society reviewers. The staff meeting was also a convenient central location to which interns could be escorted. Afternoon faculty were then able to meet their interns and escort them to their offices or hospitals for their afternoon experiences.

On Tuesday evening, Sheboygan Memorial Medical Center hosted a debriefing meeting and dinner. The evening started out with a session with the interns alone with Dr Warren Brauer acting as a facilitator. We felt that this arrangement would allow interns to express their opinions candidly, uninhibited by the presence of their physician faculty. Dr Brauer later sent me a written report on that part of the session. The faculty members and hospital administrator came in later for cocktails and dinner. Following dinner a free session was held during which all attending were encouraged to express their opinions regarding the program. All comments were positive, though some suggestions were made for improvement. All encouraged our organizational committee to plan to hold another mini-internship in 1995.

After the debriefing was completed certificates were distributed to the interns, group pictures were taken by the hospital photographer, and questionnaires were distributed to interns and faculty members.

Follow-up letters were sent to all interns and faculty members three weeks later. In the letters I thanked participants, and included a copy of the group picture.

On Nov 27, 1995, a two-page article appeared in *The Sheboygan Press.* In it, the reporter described the program and related her experiences in the operating rooms, emergency room, and physician's offices.

Producing and running the Sheboygan County Medical Society mini-internship was a time consuming, yet gratifying experience. I feel I've done my small part in improving understanding and dialog between the physicians and the leaders of our community.❖

Physician briefs

The *indicates a member of the SMS.

Steven L. Armus, MD, has joined the staff of the Mercy Walworth Center in Delavan as a dermatologist. He has been in private practice in Burlington since 1993. He received his medical degree from the UW School of Medicine and completed post graduate training, including his residency and fellowships, at Columbia Affiliated Hospitals, Morristown Memorial Hospital in New Jersey, and the State University of New York.

Chanderbahn Choithani, MD,* has been appointed assistant professor of urology at the Medical College of Wisconsin. He practiced in Milwaukee's Northpoint Medical Group for 15 years. Dr Choithani served a fellowship in urology at the University of Toronto and an internship and residency in urology at Memorial Medical Center in Savannah, Ga. He also received post doctoral training in general surgery and urology in England at Newcastle General Hospital, Stamford General Hospital in Midlands and Chase Family Hospital in Middlesex. Dr Choithani completed his medical degree and premedical education at Bombay University in India.

Victor S. Ejercito, MD,* otolaryngologist at Marshfield Clinic, has been appointed to the Sleep Disorders Committee of the American Academy of Otolaryngology.

Sharon Fleischfresser, MD, has been named medical director of the 16th Street Community Health Center in Milwaukee. Dr Fleischfresser obtained her medical degree from Baylor College of Medicine in Houston.

Martin Gadek, MD, has joined the staff of the Memorial Hospital of Burlington. A graduate of Rush Medical College of Chicago, Dr Gadek served his residency at the Mayo Clinic in Minnesota. He completed his fellowship in gastroenterology at University of Chicago Hospitals.

Robert M. Gerson, MD, has joined the Center for Plastic and Reconstructive Surgery, Mercy Health System. He graduated from the Loyola University Stritch School of Medicine and completed residencies in plastic surgery at the University of Illinois Hospital in Chicago, and in otolaryngology at Northwestern University in Chicago.

William Hendee, MD, senior associate dean for research and vice president for technology, has been named Dean of the Graduate School of Biomedical Sciences of the Medical College of Wisconsin. Before joining the Medical College in 1991, Dr Hendee was vice president for science and technology for the AMA, and adjunct professor of radiology at Northwestern University School of Medicine. He had previously served as professor and chairman of radiology at the University of Colorado Health Sciences Center. Dr Hendee was awarded a doctoral degree in physics from the University of Texas in 1962. He received his undergraduate degree from Millsaps College in Jackson, Miss, where he was subsequently awarded an honorary doctorate in science.

Allen D. Kemp, MD,* has been elected chief executive officer of Dean Health Systems, SC, a holding company recently created to oversee all Dean corporations. He will serve a five year term. Dr Kemp, who specializes in anesthesiology, joined Dean Medical Center in 1985. Daniel J. McCarty, MD, faculty member of the Medical College of Wisconsin, recently served as visiting professor at the University of Cairo and the Maadi Army Hospital in Cairo, Egypt. He also delivered the keynote address at the University of Toronto's annual Arthritis Day post-graduate course on Jan 26, speaking on "Evolving Concepts in the Crystal Deposition Diseases." Dr McCarty is a graduate of Villanova University and the University of Pennsylvania School of Medicine.

Bennett Pastika, MD, has joined the staff of Memorial Hospital of Burlington. Dr Pastika graduated from Loyola University of Chicago and the Chicago College of Osteopathic Medicine. He completed both his residency and fellowship in gastroenterology at Lutheran General Hospital in Illinois.

Mark Simaga, MD,* has joined the staff of the Richland Hospital, specializing in neuro-oncology. Dr Simaga joined Physicians Plus Medical Group a year ago. He was a previously faculty associate with the Neuro-Oncology Department at MD Anderson Cancer Center in Houston. Dr Simaga received his medical degree from Rush Medical College, Chicago, Ill, and completed an internship at MacNeal Hospital in Berwyn, Ill. Dr Simaga completed his neurology residency at Rush-Presbyterian-St Luke's Medical Center in Chicago, and then went on to complete a fellowship in neuro-oncology at MD Anderson Cancer Center.

Cary Tauchman, MD, has joined the Marshfield Clinic's urgent care department. He received his medical degree at Southern Illinois University School of Medicine in Springfield. He served his residency in pediatrics at Southern Illinois University Affiliated Hospitals.

Victoria Viegut, MD, has joined the staff of the Marshfield Clinic. She earned her medical degree from the UW Medical School in Madison. She served her residency in pediatrics at the Marshfield Clinic and St Joseph's Hospital.

Randy Waskin, MD,* has been appointed the medical director of the emergency department of Langlade Memorial Hospital. He is a graduate of Baylor College of Medicine in Houston, Tex. He completed his family practice residency at the Naval Hospital in Pensacola, Fla, and Wausau Family Practice Center. ❖

Return to work form

During the last year, the SMS Commission on Environmental and Occupational health revised the *Return to Work/Physical Capabilities Report* (Return to Work Form). Led by commission member Sridhar Vasudevan, MD, the form was revamped to make it more comprehensive, understandable, and user friendly for health care providers as well as patients and employers. Physicians, nurses in occupational health, and many others participated in the development and review of the new form. For information on how to purchase the *Return to Work* forms call Bill Guerten at 1-800-362-9080. The form can be found on page 216.❖

County society news

Brown. The Brown County Medical Society approved membership for the following physicians: Kathlene A. Kusiv, DO; Kirk Scattergood, MD; Scott Hathaway, DO; and Pamela Lois, MD.

Dane. The following physicians have been approved for membership in the Dane County Medical Society: Dianne M. Byerly, MD; Shirley J. Dawson, MD, Mark D. Erpelding, MD; Jeanne A. Griffith, MD; Paul Heinzelmann, MD; Sandra A. Herbage,MD; Eric Jager, MD; Tesu T. Lin, MD; Robert M. Mentzer, Jr., MD; Richard L. Owens, MD; Martin Plotkin, MD; Mitchell S. Sandler, MD; Aaron M. Scott, MD; Bryan S. Sires, MD; Robert J. Ware, MD; William M. Wilson, MD; and Rebecca W. Zinck, MD.

Dodge. Vincent L. Weber, MD, has been approved for membership in the Dodge County Medical Society.

Douglas. Timothy L. Burke, MD, has been approved for membership in the Douglas County Medical Society.

Eau Claire-Dunn-Pepin. Carol A. Martin, MD, has been approved for membership in the Eau Claire-Dunn-Pepin County Medical Society.

Jefferson. The Jefferson County Medical Society approved membership for Kathleen A. Kruk, MD; and Michael L. Kruk, MD.

La Crosse. The La Crosse County Medical Society approved membership for Clayton L. Ham, MD; and Debra A. Zillmer, MD.

Langlade. The Langlade County Medical Society approved membership for Randy Waskins, MD.

Milwaukee. The Medical Society of Milwaukee County approved membership for the following physicians: Mark B. Juckett, MD; Robert F. Taylor, MD; and John C. Wynsen, MD.

Oneida-Vilas. Mark E. Rassier, MD, has been approved for membership in the Oneida-Vilas County Medical Society.

Ozaukee. The Ozaukee County Medical Society approved membership for Mark R. Fitzsimmons, MD; and Milton Shapson, MD.

Racine. Gregory H. Pae, MD, and Elizabeth B. Russell, MD, have been approved for membership in the Racine County Medical Society.

Rock. The Rock County Medical Society approved membership for Robert S. Goldman, MD.

Walworth. The Walworth County Medical Society approved membership for the following physicians: Debra L. Blue, MD; Chad A. Kort, MD; Robert M. Gerson, MD; Manuel A. Rivera, MD; and Don R. Spiegelhoff, MD.

Waukesha. The Waukesha County Medical Society approved membership for James E.Bourdeau, MD; Afaf E. Mansour, MD; Nicholas E. Mischler, MD; and Dennis A. Sobczak, MD.

Waupaca. Richard P. Reigel, MD, has been approved for membership in the Waupaca County Medical Society.

Wood. The following physicians have been approved for membership in the Wood County Medical Society: Jonathan W. Kern, MD; Timothy J. Rosio, MD; Crystal T. Schlosser, MD; and Donald John Schreiber, MD.

Obituaries

Aitken, Herbert M., MD, died Oct 6, 1994. He was born on Dec 26, 1903. He received his medical degree from the University of Wisconsin, and served an internship at Cincinnati General Hospital and a residency at UW Hospital in Madison. He served as a commander in the Medical Corps of the US Navy Reserve. He practiced radiology in Eau Claire from 1952 until his retirement in 1976. Dr Aitken served as county medical examiner in Eau Claire. He is survived by his wife, Dr Katherine E. Stewart, Eau Claire.

Eichenberger, Charles R., MD, died March 7, 1995. He was born September 12, 1914. He received his medical degree from Marquette University in Milwaukee. He served an internship at St. Mary's Hospital in Milwaukee, and a residency at Columbia Hospital in Chicago. Dr Eichenberger was a member of the St. Mary's professional staff and served as team physician for the Marquette Warriors for 47 years. He was a member of the State Medical Society and the Medical Society of Milwaukee County. He is survived by his wife, Jane; his children, Lyn Miller, Carl, Ann Stamm, and Janet Balcelis; 7 grandchildren; and a brother.

Glover, Benjamin H., MD, died March 4, 1995. He was born on April 29, 1916, and received his medical degree from Northwestern University. Commissioned in the Medical Corps, US Navy, in 1943, he was trained in surgery and psychiatry in naval hospitals in Washington, Florida and Virginia. During WW II he served as fleet surgeon on the USS Phelps. He began practicing in Madison in 1947. He worked at the UW Medical School Psychiatry Department, UW Health Services, and UW Hospitals. He was also a consultant to VA hospitals and, after his retirement, became Chief of Psychiatric Services at the VA Medical Center in Tomah. Dr Glover is survived by his daughter, Sarah Gaines of Craig, Colo; a son, Jeremy, and his sister, Julie Harper of Madison.

Korst, Donald Richardson, MD, 70, of Hilton Head, South Carolina, passed away at home on Feb 4, 1995. Dr Korst was born on July 17, 1924 in Janesville, Wis. He received his BS degree from the University of Wisconsin, Madison in 1946 and his MD degree from the same university in 1948. Dr Korst interned at the University of Pennsylvania in Philadelphia prior to serving as a captain in the US Army in Germany, 1949-1951. Dr Korst returned to the University of

Continued on next page

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.❖

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FAMILY PRACTICE INTERNAL MEDICINE
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Wisconsin, Madison for his residency in internal medicine from 1951-1954. Following a one year period as a research associate in hematology at Madison, Dr Korst joined the faculty of the University of Michigan Medical School in 1955. While in Ann Arbor, Dr Korst practiced in hematology and oncology at the VA Hospital and St Joseph Mercy Hospital. In 1965, Dr Korst returned to the faculty of the University of Wisconsin, Madison in internal medicine-hematology. He later served as Assistant Dean in the Medical School. Dr Korst practiced and conducted research in hematology and oncology throughout his career. In 1978, Dr Korst joined the faculty of Boston University Medical School where he served until his retirement in 1988. Surviving are his wife, Candace Whittemore Lovely, a professional artist of Hilton Head, South Carolina; three children from a previous marriage to Marion Kuehl Applegate; Ellen K. (Reed) Hall of Marshfield, Wis; Donald K. Korst of Seattle, Wash; and Elizabeth K. (Larry) Michels of Delafield, Wis; plus six grandchildren.

Levin, Harlan M., MD, died Jan 22, 1995, in Venice, Fla. He received hismedical degree from the University of Chicago, Rush Medical College, and served an internship at Milwaukee County Emergency Hospital. He served his residencies at Milwaukee County Emergency Hospital and Northwestern University Medical School. Dr Levin was a dermatologist, and was a member of the State Medical Society, Rock County Medical Society, and the American Academy of Dermatology.

Wichgers, Ralph R., MD, died Feb 16, 1995. He was a podiatrist in the Milwaukee area for many years, and served as president of the local Podiatry Association. He was a retired Commander in the US Coast Guard. Dr Wichgers is survived by his wife, Irene, daughters Carole Kozicki and Sherrie Perrow; two grandchildren and one great-grandchild; two sisters and three brothers.❖

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4-5/95

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MILWAUKEE

PEDIATRICIAN - B/C, B/E to join Pediatric Associates in Milwaukee, St. Joseph Hospital-Sherman Park community. Competitive salary, generous fringe benefits. Reply to Malke, c/o Pediatric Associates, 4267 W. Fond du Lac Ave., Milwaukee, WI 53216. 4-6/95

JANESVILLE, WISCONSIN. Dean Medical Center, a 300 physician multispecialty group, is actively recruiting additional BE/BC family physicians to practice at the Riverview Clinic locations in Janesville, Milton and Delavan, Wisconsin. Traditional family practice and urgent care opportunities are available. Janesville, population 55,000, is a beautiful, family oriented community with excellent schools and abundant recreational activities. Excellent compensation and benefits are provided with employment leading to shareholder status. Send CV to Stan Gruhn, MD, Riverview Clinic, PO Box 551, Janesville, WI 53547 or call (608)755-3500. An Equal Opportunity Employer. 4-6/95

MADISON, WISCONSIN. Dean Medical Center, a 300 physician multispecialty group, is seeking additional family physicians to join its 30 member department. Positions are located at our Arcand Park, East Madison and Deerfield Clinic locations. All positions have an excellent call schedule and obstetrics is optional. Madison is the home of the University of Wisconsin with enrollment of over 40,000 students and the state capital. Abundant cultural and recreational opportunities are available year round. Excellent compensation and benefits are provided with employment leading to shareholder status. For more information contact Scott M. Lindblom, Dean Business Office, 1808 West Beltline Hwy., PO Box 9328, Madison, Wisconsin, 53715-0328, work at 1-800-279-9966, (608) 259-5151 or at home (608) 833-7985. An Equal Opportunity Employer. 4-6/95

JANESVILLE, WISCONSIN - URGENT CARE. Riverview Clinic, a division of Dean Medical Center, is actively recruiting an urgent care physician to join its medical staff. We recently increased our compensation package which is based on a 40 hour work week. Total compensation for Year 1 - $108,000.00, Year 2 - $134,642.00 and Year 3 - $135,000.00. We currently have two physicians which staff the clinic from 9:00 am - 9:00 p.m. Monday through Friday and 9:00 am - 11:30 am on Saturday and desire to expand the hours of operation until 9:00 pm on Saturday and 1:00 pm - 9:00 pm on Sunday. Our facility is brand new and well equipped with 8 exam rooms, lab and x-ray. Flexible hours are available with an expected total of 30-40 hours per week. Excellent compensation and benefits are provided. For more information contact Scott M. Lindblom, Dean Medical Center, 1808 West Beltline Highway, Madison, WI 53713, (work phone) 1-800-279-9966 or (608) 259-5151, Fax (608) 259-5294, (home phone) (608) 833-7985. 4-6/95

NEW OPENINGS DAILY! -- FP, IM, OB/GYN, PED. We track every community in the country, including over 2000 rural locations. Opportunities in: Appleton, Green Bay, Kenosha, Madison, Milwaukee, Chicago, Cincinnati, Indianapolis, and more. Call now for details. The Curare Group, Inc. (800)880-2028. TFN

NORTHERN ILLINOIS - Saint Anthony Medical Center, a 280-bed Level I Trauma Center in Rockford, IL, offers a tremendous opportunity for BC/BE Family Practice Physicians. Growing practice offers at least 1 in 4 call. Strong primary care physician group provides quality patient care and friendly colleagues.

RATES: 70 cents per word, with a minimum charge of $30 per ad.

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DEADLINE: Copy must be received by the 1st of the month preceding the month of issue; *eg*, copy for the August issue is due July 1.

SEND TO: *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701. FAX:608-283-5401. Classified ads are not taken over the telephone, but questions may be directed to 608-257-6781 or toll-free 1-800-362-9080.

Dynamic single and multispecialty group opportunities available for primary care physicians to join eastern Wisconsin's leading private health care provider. Current positions available in Green Bay, Two Rivers, Oshkosh, West Bend, Hartford, Pewaukee, Mukwonago, New Berlin, Milwaukee, Wauwatosa, Burlington, Lake Geneva and Kenosha. Guaranteed salary with comprehensive benefits package. Send CV to:

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Caswell/Winters and Associates
11950 W. Lake Park Dr., Ste. 200
Milwaukee, WI 53224
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4/95

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Physicians Exchange

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Offices are managed by practice management experts. Competitive salary and comprehensive benefits package offered. Saint Anthony is a member of OSF Healthcare. For more information, contact Marie Noeth at 800-438-3745 or fax CV to 309-685-2574. 4-6/95

WISCONSIN. BE/BC FP physician needed in clinic-based Urgent Care Center - part of a 35-physician multi-specialty group in west-central Wisconsin. Practice full time with some evenings and weekend hours; no call. Beautiful city of 60,000 in west central Wisconsin, 90 miles from Minneapolis/St. Paul. Competitive salary and excellent fringe package. Contact James Volk, MD Medical Director, Group Health Cooperative, PO Box 3217, Eau Claire, WI 54702-3217. (800) 218-1745. 4-7/95

WISCONSIN, LA CROSSE. Board certified residency trained emergency medicine or family practice physician needed to join four other emergency physicians at St. Francis Medical Center. 13,000 annual ER visits, 100 active medical staff members. Well-equipped community hospital with 8,000 annual admissions. Member of Franciscan Health System, currently affiliating with Skemp Clinic and Mayo to form integrated regional practice based in La Crosse. La Crosse located in scenic Mississippi River bluff country with excellent fishing, hunting, boating. Ideal family-oriented environment. Good public and private schools. Contact Charles Link, MD, Vice President Medical Affairs, Franciscan Health System, 700 West Avenue South, La Crosse, WI, 54601, 608-795-0940. 4-6/95

GENERAL SURGEON/FAMILY PRACTICE/OB-GYN/INTERNAL MEDICINE/PHYSICIAN'S ASSISTANT to join progressive 11-physician group practice. Rural college town 30 miles from St. Paul, MN. New clinic and new hospital. Contact Robert B. Johnson, MD, River Falls, WI 54022. (715) 425-6701. 3-8/95

MADISON, WISCONSIN - URGENT CARE. Dean Medical Center, a 300+ physician multispecialty group is seeking a full time physician to assist in staffing our two urgent care centers. Qualified applicants should be BE/BC in Family Practice, Emergency Medicine or Internal Medicine with experience in Pediatrics. Dean Medical Center operates two Urgent Care Centers 365 days per year, from 7:00 a.m. - 10:00 p.m. All physicians employed at the urgent care centers are paid on an hourly basis, and full time physicians are eligible to go on a shareholder track and buy into the corporation after two years of employment. Excellent compensation and benefits with shareholder eligibility after two years of employment. For more information contact Scott M. Lindblom, Dean Medical Center, 1808 W. Beltline Highway, P.O. Box 9328, Madison, Wisconsin, 53715-0328, at work 1-800-279-9966 or (608) 259-5151 or home (608) 833-7985. 3-5/95

OCCUPATIONAL MEDICINE. MINNEAPOLIS - BC/BE Occupational Medicine Physician needed to join Occupational HealthSystem Minnesota℠ of Park Nicollet Medical Center. We are a 385-physician multi-specialty clinic in the desirable Twin Cities area. Physicians that are BC/BE in family practice or internal medicine, with experience or strong interest in occupational medicine, are also encouraged to apply. Salary and benefits are highly competitive. For additional information contact Patrick Moylan at (612) 993-3286 or send CV and letters of inquiry to Physician Recruitment, Park Nicollet Medical Center, 3800 Park Nicollet Blvd., Minneapolis, MN 55416, of Fax (612) 993-2819. 3-4/95

LANCASTER, WISCONSIN. Dean Medical Center, a 300+ physician, private, multi-specialty group, is actively recruiting for one Board Eligible/Board Certified family physician to practice at the Grant Community Clinic in Lancaster, Wisconsin (population 4,200) an affiliated clinic of Dean Medical Center. Their current staff consists of three family physicians and one general surgeon. The group also has two physician assistants on staff. Each physician is at the clinic six hours a day, four days per week, seeing between 20-25 patients daily. A minimum $110,000.00 guaranteed salary plus incentive is provided. For more information please contact Scott M. Lindblom, Medical Staff Recruiter,

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Community of 2000 seeks additional Family Practitioner. Practice consists of 13 Family Practitioners, 2 Internists, 2 General Surgeons and 1 Orthopedic Surgeon. Many specialists available on a part-time basis. We are attached to a 90-bed hospital with comprehensive service available. We have a stable medical group with pleasant working conditions in a continuous growth mode.

We are 50 miles NE of the Twin Cities. We offer guaranteed first year salary with second year partnership, and excellent fringes including retirement package.

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River Valley Medical Center
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(715) 483-3221.

3-5/95

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Wisconsin Physicians working in Wisconsin.

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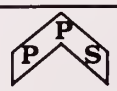

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Physicians Exchange

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BEAVER DAM, WISCONSIN. Medical Associates of Beaver Dam is actively recruiting a BE/BC family physician to join its staff of six family physicians. Call is shared equally and all hospital admissions are at our local 100 bed hospital. Beaver Dam is a safe, family oriented community of 15,000 located 45 minutes north of Madison with excellent schools and four season recreational opportunities. Excellent compensation and benefits are provided. For more information, please contact Scott M. Lindblom, Medical Staff Recruiter, Dean Medical Center, 1808 West Beltline Highway, 1-800-279-9966, (608) 259-5151, FAX (608) 259-5294 or at home (608) 833-7985. 3-5/95

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La Crosse, Wisconsin

BC/BE general pediatrician to join four pediatricians in growing multispecialty (70 physicians) group. Competitive guaranteed income/benefits. Affiliation with local hospital system and major medical center expected. Desirable midwestern, small city in beautiful Mississippi River Valley. Great family atmosphere, excellent schools and recreation opportunities.

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SKEMP CLINIC
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La Crosse, WI 54601
FAX (608) 791-9898 or
Phone (608) 791-9844, Ext. 6329

3-5/95

BOARD CERTIFIED/ELIGIBLE FAMILY PHYSICIAN invited to join a rewarding and professionally stimulating ten physician practice at the Family Medical Clinic in Amery, Wisconsin. The Family Medical Clinic is adjoined to the newly renovated 36 bed Apple River Hospital and affiliated with Ramsey Clinic, a 215 multi-specialty group practice in nearby St. Paul, Minnesota. Physicians enjoy a private-like practice setting with immediate specialty consultations, vertically integrated care, research and teaching opportunities, and financial security. Lake sprinkled Amery is an ideal home for outdoor enthusiasts and yet in easy proximity to cultural activities in the Twin Cities of Minneapolis and St. Paul. Please contact Aynsley Smith at: St. Paul-Ramsey Medical Center, 640 Jackson Street, St. Paul, Minnesota 55101-2595 or (612) 221-4230. 3-5/95

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POTENTIAL FOR
FULL TIME

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A comprehensive and competitive salary and benefit package is provided. Please submit a resume with salary history and requirments in confidence to:

Director of Personnel
Bethesda Lutheran Homes
and Services, Inc.
700 Hoffmann Drive
Watertown, WI 53094
414-261-0350

Equal Opportunity Employer

PEDIATRICIAN - BC/BE to join Pediatric Associates in Milwaukee, St. Joseph/Sherman Park community. Competitive salary, generous fringe benefits. Reply to Malke, c/o Pediatric Associates, 4267 W. Fond du Lac Avenue, Milwaukee, WI 53216. 1-6/95

NOT JUST ANOTHER RECRUITMENT AD. Opportunities at North Memorial owned and affiliated clinics will give you a shot of adrenaline because we practice in a care management environment that FPs, IMs and OB/GYNs thrive on. Guide your patients through their entire care process at one of our 25 clinics in urban or semi-rural Minneapolis locations. Plus, become eligible for $15,000 on start date. Interested BC/BE MDs, call 1-800-275-4790 or fax CV to 612-520-1564. 2,4,6,8,10,12/95

FAMILY PRACTICE physician needed by progressive and growing group practice in west central Wisconsin. City of 60,000. Ninety miles from Minneapolis/St. Paul. Primarily prepaid practice with large component FFS. Highly competitive salary with excellent fringe benefits. Practice quality care in good recreational area. Send CV to James A. Volk, MD, Medical Director, PO Box 3217, Eau Claire, WI 54702-3217; ph 715-836-8552. 2-7/95

TOMAH. Ambulatory Care. Tomah VA Medical Center seeks a BC/BE family practitioner or general internist with a strong interest in Ambulatory Care/Primary Care to join our staff. Responsibilities include direct patient care. Excellent benefit package includes malpractice protection, 30 days paid vacation, and annuity plan. Relocation expenses. 173-acre facility includes limited on-station housing. City of 8,000 in a predominantly rural area that offers affordable real estate, good schools. Conveniently located on I-90/94 midway between Milwaukee and Minneapolis. Interested candidates should contact the Associate Chief of Staff for Ambulatory Care (11F), (608) 372-1785, VA Medical Center, 500

Physicians Exchange

Continued

East Veterans Street, Tomah, Wisconsin 54660. AA/EOE. 1-4/95

NATIONWIDE - Opportunities for the following: IM, FP, OB/GYN, PED, ONC, CD, and more. Send CV to Stan Kent, Stan Kent & Associates, P.O. Box 904, Tremont, IL 61568, or call 800-831-5679, FAX 309-925-5842. 1-5/95

INTERNAL MEDICINE, CARROLL, IOWA - Outstanding professional opportunity for an internal medicine physician in a progressive, safe and clean community of 10,000 located in west central Iowa, 90 miles from Des Moines, Iowa or Omaha, Nebraska. This opportunity is available for either an in practice internal medicine physician, or the internal medicine physician just beginning practice. Excellent schools (Catholic and public), quality hospital featuring a radiation oncology center, dialysis center, and a new 32,000 sq. ft. outpatient addition. Significant income potential available. For more information, call Randy Simmons, Vice President, at 1-800-382-4197 or write St. Anthony Regional Hospital, South Clark Street, Carroll, IA 51401. 11/94-4/95

MILWAUKEE AREA. A rapidly expanding 70 physician multi-specialty clinic seeks BC/BE physicians in the following specialties: family practice, internal medicine, urology, oncology, pediatrics, general surgery and OB/GYN. Competitive salary, excellent fringe benefits. Address inquiries and CV to: Medical Associates Administrator, PO Box 427, Menomonee Falls, WI 53052-0427. 11/94-4/95

WISCONSIN: Family practitioner-Internal medicine needed by a growing practice of a four physician group in a friendly rural community in Northeast Wisconsin near Green Bay. This is an excellent opportunity to join an established organization. Highly competitive salary with benefits. Please contact: Artwich Clinic, Oconto Falls, Wisconsin 54154. 9/94-5/95

Miscellaneous

TFN

Medical Meetings - Continuing Medical Education

June 9-10, 1995

Wisconsin's two medical schools, the Medical College of Wisconsin and University of Wisconsin-Madison, will sponsor a CME program entitled "Cancer in Older People - Clinical Challenges and Practical Approaches". The course will be held Friday (all day) and Saturday (am) June 9-10, 1995, at the Grand Geneva Resort and Spa located in scenic Lake Geneva, Wisconsin. This course is designed to provide participants with state-of-the-art knowledge in diagnosis and management of common cancers in relation to the older patient. Enrollment is $100.00 and includes a comprehensive course syllabus, meals, and CME credits (12.0). The Grand Geneva Resort and Spa will offer a very special rate of $89 per night (if received by May 9th) for all participants. The resort hosts two nationally acclaimed 18-hole golf courses, indoor and outdoor swimming pools, complete fitness center and spa facilities, tennis and racquetball courts and horseback riding. Registrations for this course must be received May 26, 1995. If you would like additional information regarding this program, please call Edmund Duthie, MD at (414) 384-2000, X-2775. 4-5/95

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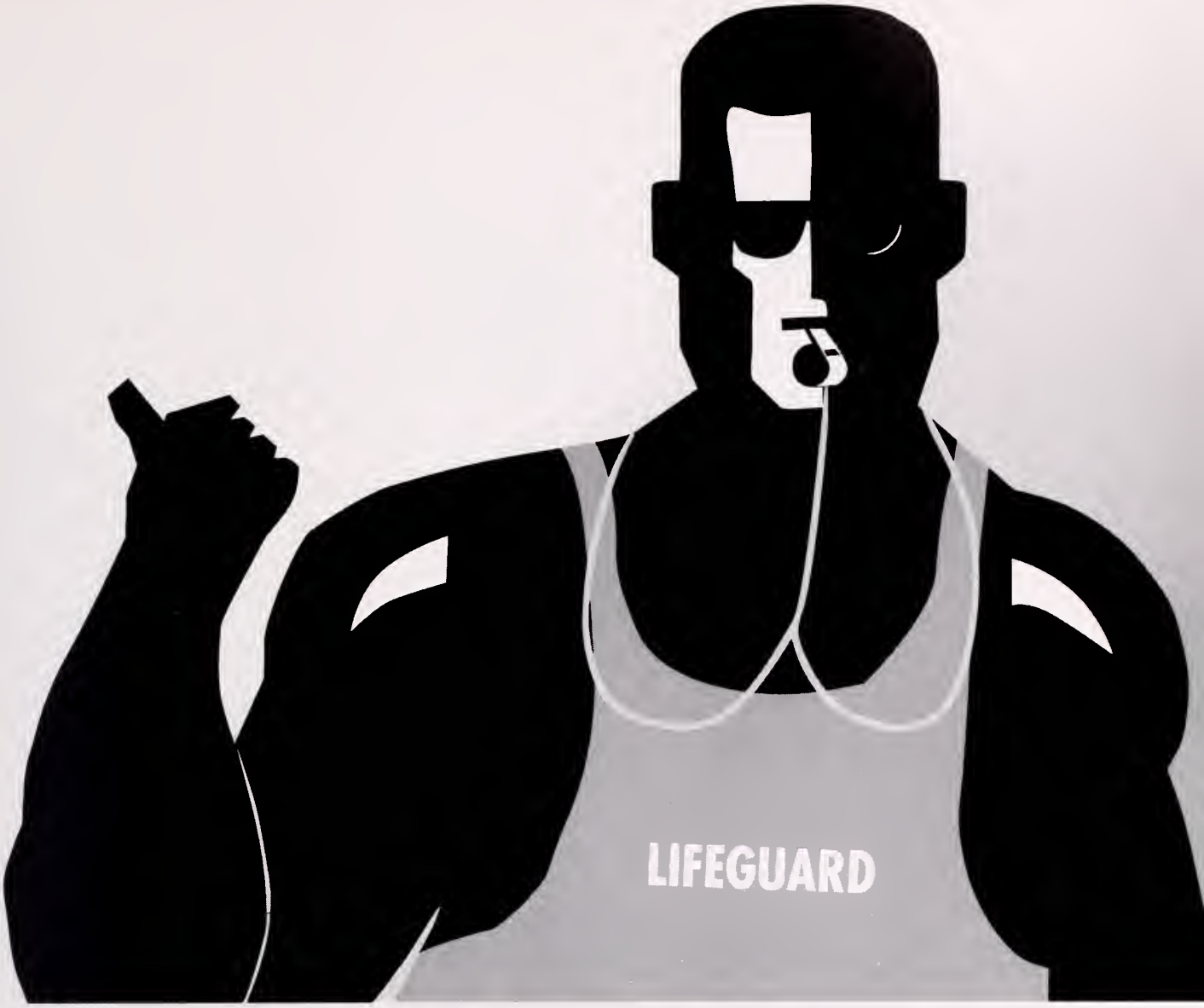
THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, clinics, specialty societies, and medical schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 70 cents per word, with a minimum charge of $30.00 per listing. *All listings must be prepaid.*

BOXED LISTINGS: $40.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 1st of the month preceding the month of publication: *eg,* copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free 1-800-362-9080.

OTHER MEETINGS in the United States are published in the first issue of each month of the *Journal of the American Medical Association.*



Everyone Out Of The Pool!

Worker's Compensation Coverage

That's what some Worker's Compensation insurers are telling clinics and physicians throughout Wisconsin. These companies want to reduce their risk by eliminating certain classes of employees and sizes of risk from their Worker's Compensation pool. In your case, this includes physicians, clinic employees, and related medical service personnel.

This is not the case with SMS Insurance Services and the Dodson Group. **We want you in our pool.** That's because SMS Insurance Services and the Dodson Group specialize in Worker's Compensation coverage for the medical community. SMS Insurance Services also offers Medical Professional Liability, a Professional Office Policy, and umbrella coverage. Our Worker's Compensation program is endorsed by the State Medical Society.

You can swim with the sharks or come where your coverage is safe. For more information about our Worker's Compensation and other SMS Insurance Services medical liability programs, contact:

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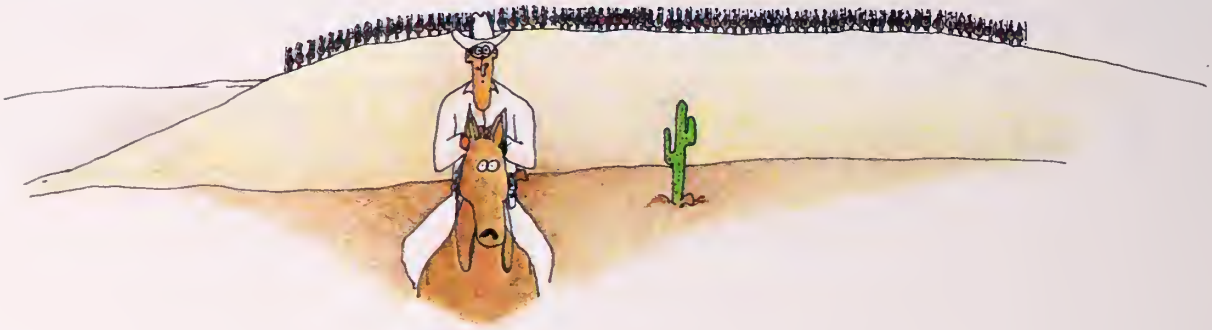

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Wisconsin Medical Journal

The *Wisconsin Medical Journal* (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor and editor are responsible for overseeing the production, business operation and contents of the journal. The editorial board, chaired by the medical editor, solicits and screens all scientific, special and soundings articles; it does not screen socioeconomic or organizational articles. The chair provides leadership for the editorial associates and comments on both editorials and letters to the editor. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *WMJ* nor the SMS take responsibility. The *WMJ* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

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Created by the Territorial Legislature in 1841 and now representing nearly 8,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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President's page
Advocacy: Breaking a path for the future

WHO ARE THE advocates for medicine? Who are the advocates for patients? Who are your advocates?

Those questions are easily posed, but not so easily answered. Who is in your corner fighting for you? Is it your spouse, your colleagues, your medical society? How can physicians do more to advocate for themselves and their patients?

When it came time for me to choose a presidental theme I was somewhat daunted by the formidable successes of past presidents: PartnerCare, CHILD SAFE and Physician's Health as well as increased domestic violence, tobacco and AIDS awareness. But then I realized as your representative, my choice was clear.

The recent SMS membership survey found that our society's number one priority is advocacy for patients and their physicians. So, your charge will be my theme. By the end of my term, it is my intent that physicians will have a clearer vision of what we can do to advocate for ourselves and our patients in the new medical environment, increasingly dominated by managed care.

Advocacy, however, is not new to the state medical society. This WMJ issue highlights many of our efforts as advocates for Wisconsin patients, their physicians, and the purchasers of health insurance (mostly employers) in the area of tort reform.

Our pursuit of this legislation has been strong and unwavering. Yet amazingly, even some doctors are not clear on the extent of the role the SMS has played in the development and passage of tort reform. When I rejoicingly remarked on the passage of a major tort reform bill, a physician colleague of mine responded that the time was ripe for tort reform and such a measure would have been adopted anyway.

Little does that individual know about the political process or the tenacity and influence of the trial attorneys! What's more, this physician will see the same reduction in malpractice insurance costs next year as I will, taking a free ride on the tort reform advocacy efforts of the SMS. Non-members will save the same number of dollars as members on their malpractice insurance (the estimated savings is more per year than the cost for SMS membership).

It's a pity that colleague and others--even SMS members--don't realize the years of effort required to get our Legislature to this point. Our recent tort reform success illustrates the tenacious needed when an individual or organization acts as an advocate.

The gestational period of advocacy initiatives is highly variable. Occasionally, one is lucky and the interest widely supported. But more commonly, concrete outcomes from advocacy initiatives take time, persistence, patience, and negotiation. Many good ideas and ideals are abandoned several times during their long journey, picked up by others who all to often receive the credit for the pioneering efforts of others.

Marcia J. S. Richards, MD

Such is the case with the tort reform bill passed by our legislature, and awaiting the signature of the governor as I write this message.

Recorded in the transactions of the SMS in 1891 (yes, you read that

Continued on next page

Continued from preceding page
correctly) Dr. Gill wrote: "Cases of civil malpractice are of frequent occurrence. The frequency with which suits of this character are brought is increasing with such rapidity, that it suggests to the mind of the practitioner of medicine that it is highly important that the profession awaken to the realization of the situation, and make and honest effort to restrict the suits within their narrowest limits." More than 100 years later, Dr. Gill would applaud our efforts towards his goal.

Jumping forward to 1975 (in the interest of space), four leaders of our society--accompanied by 300 SMS members in the gallery-- testified in favor of a Senate bill to limit total awards to $250,000 and attorneys fees to 20%. It did not pass. We made limited progress in 1978 with passage of laws to lower the statute of limitations for minors in medical malpractice cases. Society presidents wrote repeatedly in the following years about tort reform, but more importantly Wisconsin physicians became politically active, getting to know their governmental representatives and supporting them in campaigns for office. In 1985, 800 SMS members showed up at a legislative reception in Madison! We didn't get what we wanted, but we did get a $1 million dollar cap on non-economic damages.

In 1986, we joined the Wisconsin Coalition for Civil Justice with 70 business, professional and nonprofit associations to promote tort reform focusing on 8 key issues. A bill with five of those provisions was introduced a year later. We were again not successful, but kept trying and targeted tort reform for 1989-1990. We managed, the following year, to get the votes to pass a $250,000 cap on non-economic damages only to have it blocked in committee by a non-ammenable measure that eliminated the sunset on the inadequate $1 million cap. We were discouraged but not defeated.

Yet we pursued. We commissioned Gallop to provide a database of consumer attitudes toward health care issues, including professional liability. Eighty percent of Wisconsin citizens replied that we, their physicians, were paying too much for malpractice insurance; an equal number supported limiting the awards for "pain and suffering." In spite of public support we were unsuccessful for 3 years in reducing the $1 million dollar cap on non-economic damages to $250,000 and then, after it expired, spent 4 more years trying to get a cap put back in place.

Finally, now in 1995, we appear to have achieved a measure of success. Our advocacy efforts we believe have paid off. But without the personal and financial support of SMS members over many years, major tort reform, I believe, would not have occurred. Even those of you who just paid dues over the years have contributed significantly to this effort.

Let's remember the lesson taught by saga of tort reform as we face these difficult times for medicine. Samuel Johnson had obviously learned that lesson as well when he commented, "Great works are performed not by strength but by perseverance."

But as we breathe a sigh of relief now that this tort reform battle has been won, let us also remember that our victory will be only fleeting if we do not pass on to our patients the savings we see as the result of this legislation. Our adversaries will remain vigilant and we must prove to ourselves and our patients that tort reform is a portion of the path to controlling health care costs and increasing access.❖

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

Editorials are signed by the authors. These opinions are the authors' and do not necessarily reflect the policies of the SMS. Authorship of editorials is reserved for members of the *WMJ* editorial board, editorial associates and SMS elected officials.

Letters are signed by the authors. These opinions are the authors' and do not necessarily reflect the policies of the SMS. Authorship of letters is open to the public, but letters are limited to 500 words and subject to review by the *WMJ* editorial board. Write to: *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701.❖

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EVP report: The view from here
Incipit vita nova

DANTE'S LITTLE RUBRIC (The new life begins.) seems a fitting title here, for it seems that change is upon us with vigor. With the governor's signing of the tort reform bill, an era of endurance and frustration has come to a hopeful end for the SMS and Wisconsin's physicians. (You'll find plenty more said on this topic elsewhere in this *WMJ*.) But the era of tort wars is not the only period coming to a close.

As you saw from last month's *WMJ*, the medical journal is undergoing a change in leadership. After 18 years on the editorial board and almost 9 years as medical editor and editorial board chair, Dr Richard Sautter is moving on to new and more personal challenges.

The new medical editor and editorial board chair is Thomas C. Meyer, MD, of Madison. Dr Meyer is an emeritus professor of pediatrics at the University of Wisconsin Medical School, director of the school's office of continuing medical education, and, until his recent retirement, vice president of medical affairs at St Mary's Hospital Medical Center in Madison. He has had industrial medicine and private pediatric practices in South Africa, and practiced as a paediatric cardiologist at the University of Wisconsin's Center for Health Sciences.

Dr Meyer has been an active participant in shaping the future of his profession and of organized medicine. In addition to serving on several committees at the university and medical center, he has given his time and effort to WIPRO, the Wisconsin Heart Association, the Wisconsin Regional Medical Program, the AMA, the ACCME, Association of American Medical Colleges and others. At the SMS, he has served as alternate and delegate to the House of Delegates, as a member of the Peer Review Committee, the Utilization Review Plan, the Commission on Scientific Medicine, the Emergency Medical Services Committee, and the Commission on Continuing Medical Education.

Much of Dr Meyer's experience centers on issues of quality of care and medical education, and the SMS Board of Directors viewed this experience as a strength he will bring to the *WMJ*. He is also known as a man who likes to be creative, to try out new ideas, so it will be fun to watch as his influence begins to show in the journal.

On behalf of the SMS staff, I offer Dr Meyer a hearty welcome.

But before we get too far, we need to stop and express appreciation and admiration for the many things Dr Sautter accomplished with the *WMJ*. The leadership he provided to the members of the editorial board and to the communications staff caused the journal to shake loose the shackles of the past, try a number of creative changes and become a publication that inspires both pride in the members of this state society and envy in the members of most others.

Even the most casual observer can point to a long list of innovations implemented under Dr Sautter's leadership, including: a new look and new feel to the journal; enhanced standards for scientific publishing; writing competitions for medical students, residents and graduate nursing students; increased coverage of socioeconomic and organizational news; physician photo competitions; and even medical crossword puzzles and comics, to name only a few.

Not every experiment proved successful, and some had short but worthy lives, but this is, perhaps, as it should be. The will to try new ideas is rare, particularly when combined with the fortitude to withstand those who fight for the status quo, and this combination of characteristics distinguished Dr Sautter's term as medical editor. The members of the SMS and other readers of the *WMJ* owe him a great debt of gratitude and their best wishes for his continued success.

Thomas L. Adams, CAE

Finally, there is a shorter, quieter era coming to an end, but it warrants noting even if it is less visible: After more than 7 years with the SMS, Russell King--our current director of communications--is leaving us to serve the Wisconsin Homecare Organization as president and executive director. Russ came to us to edit the *WMJ*, but over the years brought us, among other things: creative covers; contemporary, yet dignified, layouts; cost-effective and time-saving changes in the production process; a nationally acclaimed public health column; several courageous attempts to enhance advertising rev-

Continued on page 237

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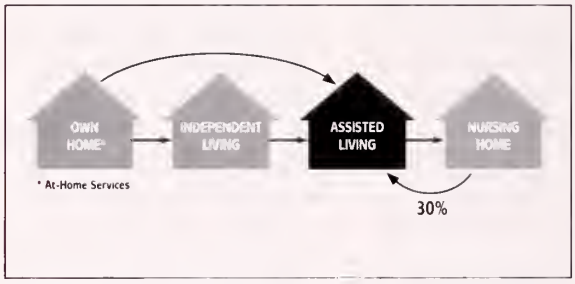

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Continued from page 235
enue; and a new approach to press and public relations.

Educated as a journalist, certified in medical writing and editing, and honored as a poet, Russ provided us with a rare behind-the-scenes versatility, and SMS staff, officers, and more than a few member physicians learned that if a noun and verb had to be hooked to achieve a specific effect, you asked Russ to do the hooking for you. But the hallmark of his time here has to be the zeal he brought to his work. His esteem for the medical community made him one of the most passionate physician advocates I've known (prudence requiring even me to rein in his fervor from time to time). The SMS was not just a job to Russ, it was a mission.

Even while we seek his successor--you can't "replace" that odd mix of traits--we wish him well on his new quest.

New adventures seem to be the order of the day--for Russ, for Dr Meyer and Dr Sautter, and for the SMS--and it is an invigorating time. We can pause a moment to enjoy our accomplishments and to thank those who have served us, but then the torch must be passed and we must turn our eyes to tomorrow. The new life, indeed, begins.❖

United we stand

I AM PLEASED TO announce that on Wednesday, May 10, 1995, at 8:45 AM, genuine tort reform completed its long and tortured path when Gov Tommy Thompson signed into law a vital bill of tort reform, capping non-economic damages in medical liability cases at $350,000.

This victory should serve for us as a symbol of what we can do when we work together, because it would never have been achieved without the combined efforts of a large number of physician volunteers and dedicated staff members. I note, in particular, past SMS president Dr Bill Treacy, Immediate Past President Rich Rboberts, former chair of the SMS medical Liability Committee Dr Bill Listwan, and our Capitol team: Mike Kirby, Kathy Anderson, and Colleen Wilson.

While they have been the stars of our campaign, the credit for this victory must be shared with the entire SMS staff and a host of physician leaders, key contacts, commission members and chairs and grassroots activists. It has always been the collegial atmosphere and respectful working relationship among staff and physicians that has set this medical society apart, so it is fitting that it was our ability to pull together that has gained us this milestone. *--T. Adams* ❖

Letters

Well done

TO THE EDITOR: Congratulations! It must be enormously satisfying to have finally succeeded in reaching the top of the tort reform mountain. Please express our praise and appreciation to the SMS leadership, the staff, and all the physicians who ceaselessly and resolutely fought to achieve balance in the tort system for medical professionals.

--William T. Montei, CEO
PICWisconsin
Madison❖

In support of Contract with America

TO THE EDITOR: I was distressed that the president of the State Medical Society of Wisconsin used the *Wisconsin Medical Journal* to parrot recurring criticisms of the liberal legislators and press to criticize Congress' Contract with America.

If our medical society president would honestly review the provisions of the Contract and particular proposed spending for food supplements, the elderly and the poor, he would find that more money is being spent and not less. It has often been said that is a lie is repeated often enough, it soon will take on the character of truth. From 1964 to 1992 we have spent 5.4 trillion (yes, trillion) dollars on our social welfare programs. During this time it has simply not worked and has resulted in an increase in poverty, increase in crime rate and an increase in illegitimate birth rate. Our society cannot stand this ever escalating expense which only increases the problem and is painfully obvious that a change is in order. Change will always be painful to some segment of the population no matter what endeavor is carried out.

We simply cannot continue to go down the road of escalating problems with our current policies which are continually made worse by the increasing federal bureaucracy.

--John W. Utrie, MD
Green Bay❖

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Use of advance directives: a survey in three clinics

Mary Ann Gilligan, MD, MPH, Seattle, and Norman Jensen, MD, Madison

Advance directives (ADs) are instructions from patients to their physician and family regarding their wishes for medical care in the event they become incapable of communicating those wishes. This study sought to describe the characteristics of adults who have completed advance directives and those who have expressed interest in them, and to determine what distinguishes these groups from the group with no interest in ADs. A further objective was to survey the study population on the barriers to completion of ADs. A random sample of 160 outpatients visiting one of three clinics (General Internal Medicine Clinic (GIM), HIV Clinic, and Oncology Clinic) were selected for the study. A 10-item questionnaire was administered which included questions on familiarity with, sources of information on, and interest in ADs. Demographic information was collected as well as information on subject experiences with illness and death. Twenty-six of the 160 participants (16%) had completed ADs. The prevalence of completion differed among the three clinics: HIV Clinic 25%, Oncology Clinic 18%, and GIM Clinic 8%. Nearly all patients (95%) expressed interest in ADs. Those not interested in ADs were more likely than those who were interested or those who had already completed ADs to have been in an intensive care unit themselves. Multiple barriers to completing ADs were identified. Advance directives are still used by relatively few people despite a general openness and interest in them. Few characteristics, demographic and otherwise, were identified to distinguish those who completed ADs from those who did not. *Wis Med J.1995;94 (5):239-243.*

The idea of advance directives gained acceptance in the 1960s as medical care became increasingly technology-driven and there was concern about being "kept alive" by machines with no hope of meaningful recovery. Over the last several decades nearly every state in the US has recognized advance directives in one of three forms: (1) Directive to Physicians in Natural Death Acts; (2) living will (LW); or (3) Durable Power of Attorney for Health Care (DPAHC).

A living will is a written statement of a person's wishes regarding the use of specified medical treatments to be followed if that person is unable to provide instructions at the time the medical decision needs to be made. Living wills are commonly limited to decisions about life-sustaining procedures in the event of terminal illness. The DPAHC is distinct from the living will in that it establishes another individual to act as that person's agent should the person be unable to provide instruction. The DPAHC applies to all medical decisions, unless specifically limited, and can include special instructions to the agent.

In 1989 Wisconsin enacted a DPAHC statute (Wisconsin Act 200) which took effect April 28, 1990.[1] In 1990 advance directives gained renewed public interest with the US Supreme Court ruling in the case of Nancy Cruzan, a young Missouri woman who was in a persistent vegetative state after a motor vehicle accident.[2] Her parents' request to stop nutrition was blocked by the Missouri Supreme Court. The US Supreme Court overruled the state's decision, finding if a patient has left clear and convincing evidence as to his or her wishes for health care, life-prolonging equipment may be removed. This decision gave a heightened status to advance directives.

This study examined the use of advance directives at the University of Wisconsin Hospital and Clinics in the spring of 1991 after the Durable Power of Attorney for Health Care statute had been in effect for approximately one year and in the wake of discussion over the Cruzan case. We were interested to see whether recent local and national attention had stimulated interest in advance directives. The purpose of the survey was to determine who was using advance directives, and

what were attitudes toward advance directives and barriers to their use in ambulatory clinic patients.

Methods

Participants were recruited from patients visiting three primary adult care clinics at University of Wisconsin Hospital and Clinics: General Internal Medicine (GIM) Clinic, HIV Clinic, and Oncology (Onc) Clinic. Subjects were selected through a systematic sampling scheme: every other, or every third, patient on each caregiver's list for a given clinic day was targeted, depending on the number it was feasible to interview. Caregivers were given the option of removing a patient from the study sample due to incapacity. All participants gave written consent prior to participating in the survey. The study was approved by the University of Wisconsin Human Subjects Review Committee and by participating clinic physicians.

A 10-item questionnaire was administered to all participants. The questionnaire covered such topics as whether subjects were familiar with the terms "Advance Medical Directives," "Living Will," and "Durable Power of Attorney for Health Care." If participants had knowledge of such terms, they were asked to indicate sources of information on ADs by marking as many as were applicable. Sources listed included newspaper, radio, television, friend or family member, physician, other health care worker, and other.

Table 1.—Clinic Characteristics.

Characteristic	GIM Clinic (% or mean) (n = 62)	HIV Clinic (% or mean) (n = 48)	One Clinic (% or mean) (n = 50)	p-value
Sex				
Female	63%	8%	66%	<.01
Male	37%	92%	34%	
Age, years	44 (range 20-85)	37 (range 20-69)	52 (range 21-81)	<.01
Single*	29%	56%	6%	<.01
At least one child	61%	29%	84%	<.01
Education				
High school or less	28%	44%	54%	=.05
College or greater	72%	56%	46%	
Chronic Illness	37%	100%	100%	<.01
Death of a loved one	84%	90%	90%	=.59
ICU-self**	29%	21%	30%	=.53
ICU-Friend/Family	74%	75%	82%	=.58
ICU-Death	37%	42%	32%	=.61
Advanced Directive Complete	5/62 (8%)	12/48 (25%)	9/50 (18%)	=.05
Interested in AD	57/62 (92%)	47/48 (98%)	49/50 (98%)	=.19

*as opposed to married or in a primary relationship
**ICU = intensive care unit

After a brief introduction to Wisconsin's DPAHC document, participants were asked whether they would be interested in completing such a document in the future and why or why not. Demographic information included: sex, age, marital relationship status, education, and number of children. Participants were asked whether they had a chronic illness that affected their daily activities. In addition, four predictor variables were included to quantify a participant's prior experience with illness and death. Participants were asked: (1) whether they had ever experienced the death of a loved one; (2) whether they had ever been cared for in an intensive care unit (ICU); (3) whether they knew anyone who had been cared for in an ICU; and (4) whether they knew anyone who had died while being cared for in an ICU.

All questionnaires were administered by one of us (MAG) either before or after the patient's clinic visit. Interviews were conducted on successive days that the interviewer was available until the target number of participants were interviewed. A total of 160 interviews were conducted. Results were analyzed on SPSS software using chi-square, t-test, and ANOVA procedures.

Results

Of 182 patients approached to be

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interviewed, 160 agreed to participate in the survey, for an overall response rate of 88%. The single most stated reason (54.5%, n = 12) for refusing to be interviewed was not wanting to take the time.

The three clinic populations differed in their demographic characteristics (Table 1). The HIV Clinic had a higher percentage of men, had a lower mean participant age, and had a higher percentage of single people than either the GIM Clinic or Oncology Clinic. Participants from the HIV Clinic also had fewer children than did subjects from the other two clinics. Levels of education differed significantly for participants among the three clinics. The GIM Clinic had the highest percentage of participants who were college educated (72%), the HIV Clinic had 56%, and the Oncology Clinic had 46%. The three populations did not differ significantly in their prior experiences with death of a loved one and intensive care units. Twenty-six of the 160 participants (16%) had completed ADs. Patients in the HIV and Oncology Clinics were significantly more likely to have completed ADs than those in the GIM Clinic (GIM 8%; HIV 25%; and Oncology 18%).

The 26 participants who had completed ADs, as compared to the 133 who had not, were more likely to be: (1) male, (2) single, and (3) without children, reflecting the large contribution from the HIV Clinic. To overcome this influence clinics were analyzed individually (Table 2). The only statistically significant differences among the demographic characteristics analyzed was an association between older age and having completed ADs in the GIM and HIV clinics. None of the four predictor variables were found to be significantly different between those who had completed ADs and those who had not.

The majority of participants in all three clinics expressed interest in ADs (Table 1). There were too few in the "not interested" group in both the HIV and Oncology Clinics to make comparisons. In the GIM Clinic there was a significantly higher proportion of those people who had been in an ICU themselves in the "not interested" group than in the "interested" group ($\tilde{n}$ = .02, Fisher's Exact two-tail, data not shown).

When participants were questioned about their sources of information on ADs, 27 (17%) who had heard of ADs identified their physician or other health care provider as a source of information. Five patients (30%) who had completed ADs identified their physician or other health care provider as a source of information. Forty-eight percent of those having completed ADs identified "Other" as a source of information, specifically, attorney (10), and the Madison AIDS Support Network (3).

After an introduction to the Wisconsin DPAHC, participants were asked to list any reservations they might have about completing such a document (open-ended). The responses fell into five major categories: (1) need more information/time to think about it (28.1%); (2) difficulty choosing a proxy (need to find someone I can trust/someone who has the same values as me/don't want to put that burden on someone) (28.1%); (3) don't like to think about these types of issues (9.4%); (4) fear that the document will be used to deny care ("What if I change my mind?"); fear of abuse ("I don't want to be taken before my time"); general distrust of the medical profession (20.3%); and (5) Difficulty filling out the forms ("You can never cover all the bases") (10.9%). These same concerns were shared by those who had already completed ADs, those who were interested but had not completed ADs and those who were not interested. An additional response given by two participants who were not interested was that it was not necessary.

Discussion

In the present study we examined AD use in an adult population ranging in age from 20 to 85. We found significant interest in ADs (overall 95%). Still, only 26 (16%) of the 160 participants interviewed had completed ADs. There was an association between chronic illness and older age in having completed ADs. In the present study, participants were well-educated in general, with more than 50% having completed college. Those who had completed ADs did not have a higher education level as a group than those who had not completed one. We found that physicians and other health care providers were not a major source of information about ADs for either those who had completed ADs or those who had not. Many of those who had completed ADs had learned of them through lawyers. Another popular source of information about ADs was the local AIDS support network. Barriers to filling out ADs included: (1) need more information/time; (2) difficulty choosing a proxy; (3) don't like to think about these types of issues; (4) fear of being denied care; and (5) difficulty filling out the document.

The percentage of participants having completed ADs in our study is consistent with other estimates.[3] Other investigators have analyzed their study populations to distinguish those who have completed ADs from those who have not. Stelter et al[4] found that those who completed ADs were highly educated, and did not consider the document too long for its purpose. In our study, we did not find education to be a significant variable; our population was well-educated as a whole. We did not assess attitudes about length of the forms directly, although length was not revealed to be a barrier in the open-ended question asking for comments on the DPAHC. Teno et al[5] found that patients with HIV-related diseases who had filled out ADs were more likely to have the following characteristics: (1) male, (2) homosexual (as opposed to other risk categories), (3)

Table 2.—Intra-clinic characteristics: Completed ADs vs. not completed ADs.

Characteristic	GIM Clinic AD (n=5)	GIM Clinic No AD (n=57)	p-value	HIV Clinic AD (n=12)	HIV Clinic No AD (n=36)	p-value	Onc Clinic AD (n=9)	Onc Clinic No AD (n=41)	p-value
Sex									
Female	60%	63%	1.0	0%	11%	.56	56%	68%	.47
Age, years (mean)	56	43	.05	41	33	.04	53	50	.49
Single*	60%	26%	.14	69%	51%	.27	13%	17%	1.0
At least one child	60%	61%	1.0	23%	31%	.73	89%	83%	1.0
Education									
High school or less	0%	32%	.45	39%	49%	.82	33%	59%	.53
College or more	100%	71%		46%	43%		56%	32%	
Chronic illness	40%	37%	1.0	100%	100%	--	100%	100%	--
Death of a loved one	100%	83%	.58	92%	73%	1.0	89%	90%	1.0
ICU-Self**	0%	32%	.31	31%	20%	.46	22%	32%	.71
ICU-Friend/Family	100%	72%	.32	77%	74%	1.0	78%	83%	.66
ICU-Death	20%	39%	.64	62%	37%	1.0	56%	27%	.10

*as opposed to married or in a primary relationship
**ICU - intensive care unit

>HS education, and (4) duration of AIDS >13 mos. The ability to make these distinctions would require a more heterogeneous HIV-positive population than that in the HIV Clinic studied for this survey.

Many studies have tried to identify the barriers to filling out ADs. Roe et al[6] cite the major barriers to completion of ADs in their study as (1) lack of awareness about the forms, (2) difficulty in choosing a proxy, and (3) family/physician should make the decision. In Stelter's study, barriers were family issues (upsetting to family members) and the need for assistance on completing the forms. Sachs et al[7] found that procrastination was the main reason identified by patients for not filling out the forms. Emanuel et al[8] cites lack of physician initiative as a major reason. These barriers are similar to the ones identified in our study. An additional barrier identified in our study was fear. Patients feared that if they fill out such a document then change their mind, but don't change the document, they will be held to what is written. This was also expressed as a fear of being "taken before their time." Underlying this fear seemed to be distrust of the medical profession's ability\commitment to look after the patient's best interests. This latter barrier is interesting in the context of our finding that a higher percentage of patients who had themselves been patients in an intensive care unit were not interested in the DPAHC. Although the reasons for their lack of interest were not explored in depth, it is plausible that a relationship exists between their resistance to completing ADs and their fear that they would not be given the full ICU treatment should they fill out AD forms.

A feature of our study worth noting is that its population comprised a wide age spectrum. This is in contrast to most surveys in the literature which examine use of ADs in the elderly or a specific population, eg, HIV-positive persons. This is important in light of the fact that the case bringing the issue of ADs to the fore involved a young woman.[2] Our study also tried to understand the use of ADs in terms of life experiences, ie, experiences in intensive care units and experience with death. The study is limited by the small sample size, especially when making intra-clinic comparisons.

Widespread use of ADs has not occurred despite considerable public interest in them. The Patient Self Determination Act[9] which requires that health care facilities receiving federal funds inform patients upon admission of their right to an advance directive, has not had the impact that was hoped for.[10] Barriers to their widespread implementation have been identified in our study as well as others. Physicians and other health care providers can make greater efforts to discuss these end-of-life issues with their patients.

Physician barriers to facilitating the process of AD completion were not examined in this study and require further research.[11,12] The effectiveness of ADs in assuring end-of-life care consistent with patients' wishes has yet to be shown. The stability of patient preferences regarding end-of-life decisions is currently an active area of research.[13] Patient barriers may prove more difficult to overcome, in particular the fear surrounding their use. Increased familiarity with ADs and discussion of them with physicians and other health care providers will be helpful in allaying fears.

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Interdisciplinary treatment of the injured worker with chronic pain: long-term efficacy

Ward R. Jankus, MD; Tai J. Park, MD; Marni VanKeulen, PT and Mary Weisensel, MSW, Menasha

The purpose of this study was two-fold: (1) to determine long-term efficacy of an outpatient interdisciplinary pain treatment and management program for injured workers with chronic pain, and (2) to determine if those referred earlier after injury are more likely to benefit. Ninety-one questionnaires were completed a median of 36 months following program completion. Ninety-three percent of patients reported improvement in pain symptoms at the time of program discharge and 76% reported maintenance or improvement of pain level between discharge and the time of survey. Of those not working at the time of initial evaluation, 74% reported return to work or current involvement in a retraining program. Patients referred ≤ 12 months after injury reported greater mean pain improvement and were significantly more likely to return to work. We conclude that the interdisciplinary pain treatment and management approach is effective in treating injured workers with chronic pain and that early referral enhances outcome. *Wis Med J.1995;94(5):244-248.*

Over the past few decades the interdisciplinary pain program approach for treating the patient with chronic pain, first widely popularized by Bonica,[1] has been growing in popularity. We undertook this study to (1) determine long-term efficacy of an outpatient interdisciplinary pain treatment and management program in the treatment of the injured worker suffering with chronic pain, and (2) to determine if those referred earlier following injury are more likely to benefit.

Approximately one fourth of our patients treated are persons with industrial injuries. Indications for referral include the following: unclear diagnosis after repeated evaluations, failure to control pain symptoms, failure to return to and remain at work, inappropriate use of medications, and escalating patient and family psychosocial distress. An individual program is designed and implemented for each patient using an interdisciplinary team approach with a physician experienced in pain medicine functioning as the team leader. Other team members include a physical therapist, occupational therapist, psychosocial staff, and the patient. Treatment options available include medication management, selective therapeutic injections, therapeutic exercise instruction, biofeedback, education in body mechanics/back conservation skills, stress management, and instruction in pain coping strategies.

While a variety of outcome study measures have been reported in the literature, those of particular interest to us were (1) subjective pain improvement between the beginning and end of the program, (2) maintenance of pain improvement

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Table 1.—Patient questionnaire.

1. At the completion of your program how much better was your pain compared to when you started the program? (Circle a percent)

   0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
   (pain no better- > pain was gone)

2. In general, how is your pain now compared to when you finished the program?

   ❑ The pain is worse.
   ❑ The pain is about the same.
   ❑ The pain is better.

3. How much do you feel your program helped you learn how to cope with and manage your pain ? (Circle one)

Did not help at all	Helped a little	Helped a fair amount	Helped a great deal

4. A. Have you been employed at any time since completing your program?
   Yes ❑ No ❑

   If No, briefly describe why not.

   B. Are you currently employed? Yes ❑ No ❑

   If No, have you been employed at any time in the past 6 months?
   Yes ❑ No ❑

between the end of the program and the time of the follow-up study, (3) usefulness of the program in helping the patient learn how to cope with and manage their pain, and (4) return to work.

We report here the results of a questionnaire answered by patients a median 36 months after program discharge followed by a discussion of some issues surrounding pain program outcome studies and recommendations for improving treatment of injured workers.

Methods

A total of 223 charts representing all industrial injury patients initially evaluated between June 1989 and December 1992 were reviewed. Of those 223, 158 were enrolled in the comprehensive outpatient interdisciplinary pain program, while the remaining 65 were either seen for only a single visit (n=23), or were treated solely by the physician +/- a brief course of physical therapy (n=34), or were referred to an outside physician (n=8). Of the 158 enrolled in the comprehensive program, 139 went on to complete the program.

In April, 1994 questionnaires were mailed to those 139 patients who completed the program. A second mailing was sent to those not responding to the initial mailing. Finally, telephone contact was attempted at least twice and responses obtained over the telephone with those not responding to either mailing. A copy of the questionnaire is displayed in Table 1.

All statistical analysis of the data in this paper was accomplished using the Minitab, Inc. statistical software package, Release 10 (for Windows).

Results

Demographic data. A total of 91 responses (47 after the first mailing, 35 after the second mailing, nine via telephone) were obtained, representing a 65% response rate. Seventeen questionnaires were returned unopened with no forwarding address and two were returned with the notation that the addressee had died. Of the remaining 29 patients presumed to have received the questionnaire, five stated they did not want to answer any questions (one by mail and four by phone) and the remaining 24 neither returned the questionnaire nor were reached by telephone on at least two attempts.

Of the 91 patients responding, 49% were female. Average number

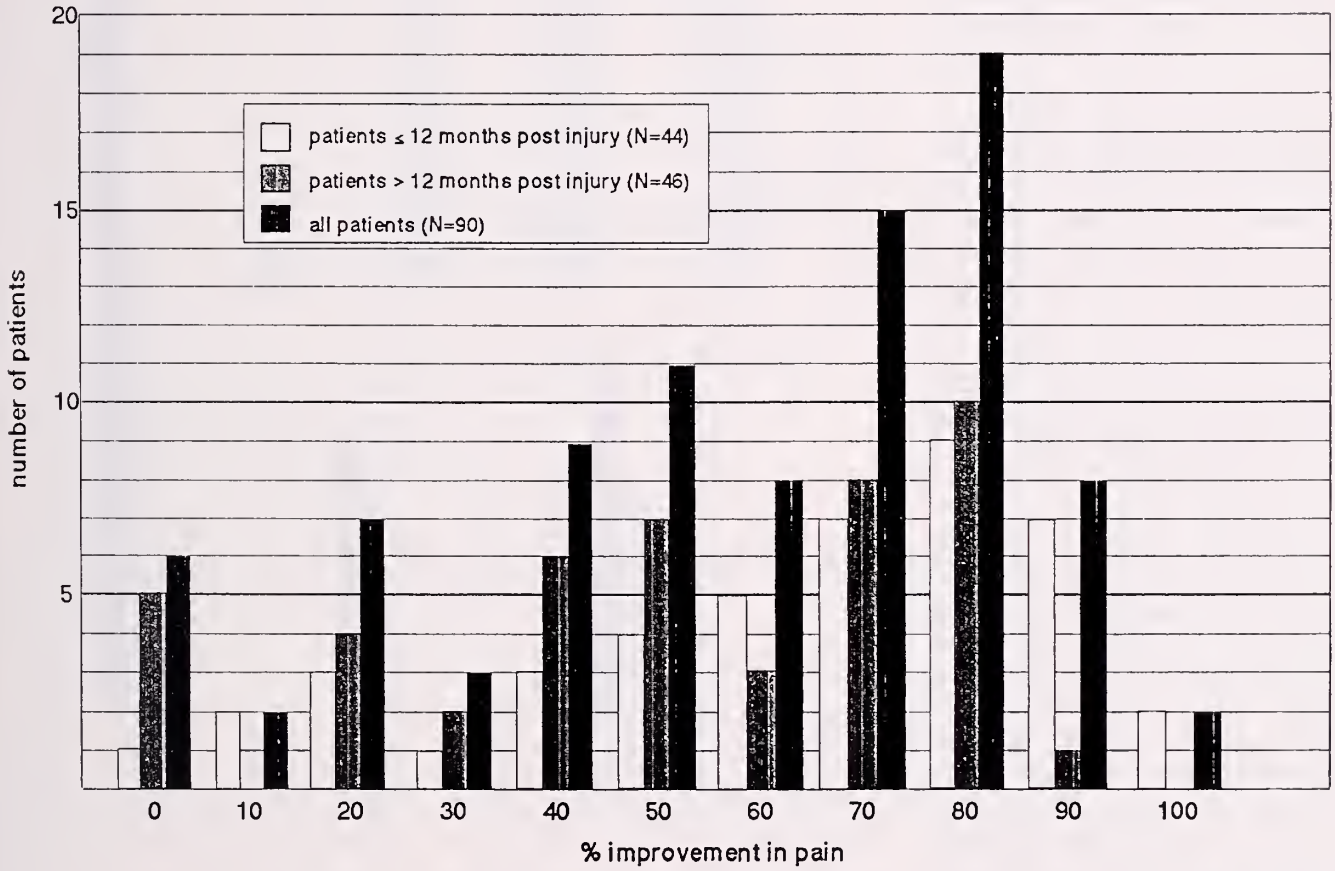

Fig 1.-At the completion of your program how much better was your pain compared to when you started the program?

of physicians seen for pain problem prior to referral was 3.0. Median time between industrial injury and initial program evaluation was 12 months. Median time between discharge and the questionnaire mailing (April 1994) was 36 months.

Study responses. Displayed in Figure 1 is the response to the question "At the completion of your program, how much better was your pain compared to when you were first seen at the clinic?" Ninety-three percent of patients reported improvement in pain level, with the first and second most frequent responses being improvement of "80%" and "70%," respectively. The mean percentage improvement for those patients referred $\leq$ 12 months after injury, 63.0 (SE = 3.9), was significantly different from the mean for those patients referred > 12 months post injury, 51.3 (SE = 3.9), $t = 2.01$, $p < 0.05$. Also, those patients reporting "90%" or "100%" improvement were significantly more likely to have been referred $\leq$ 12 months after injury ($X^2 = 7.61$, $p < .01$).

Displayed in Figure 2 is the response to the question "How is your pain now compared to when you completed your program?" Seventy-six percent reported either no change in pain level (19%) or further improvement in pain level (57%), while 24% reported a worse pain level. There were no significant differences using chi-square tests between those referred $\leq$ 12 months after injury and those referred >12 months after injury.

Displayed in Figure 3 is the response to the question "How much did your program help you cope with and manage your pain?" Ninety-eight percent of patients reported that the program helped to some degree, with the most common response (50% of patients) being that it helped "a great deal." There were no significant differences using chi-square tests between those referred $\leq$12 months after injury and those referred >12 months after in-

Table 2.—Return to work outcome of those patients not working at time of initial evaluation

	Patients referred < 12 months after injury	Patients referred > 12 months after injury	All patients
Returned to work	17 (77.3%)	12 (48.0%)	29 (61.7%)
Currently in job retraining program	3 (13.6%)	3 (12.0%)	6 (12.8%)
Never returned to work	2 (9.1%)	10 (40.0%)	12 (25.5%)
Total	22 (100%)	25 (100%)	47 (100%)

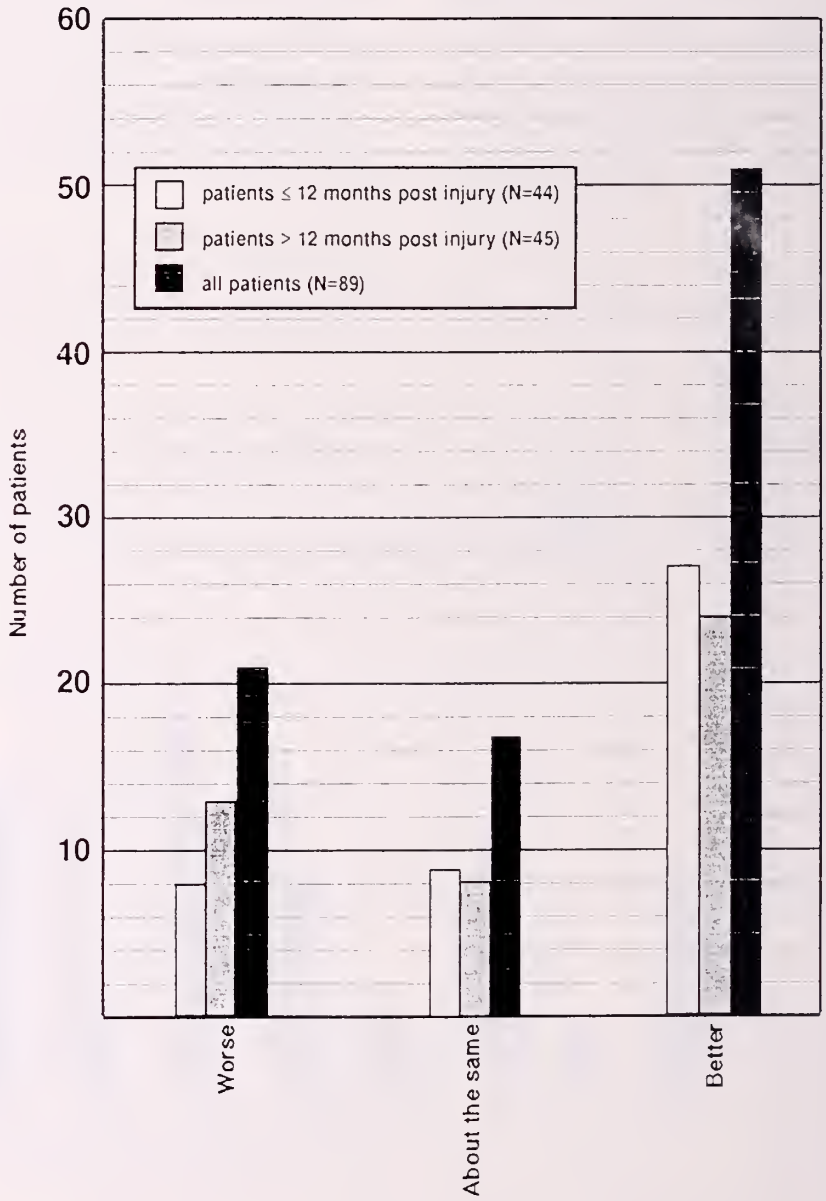

Fig 2.-In general, how is your pain now compared to when you finished the program?

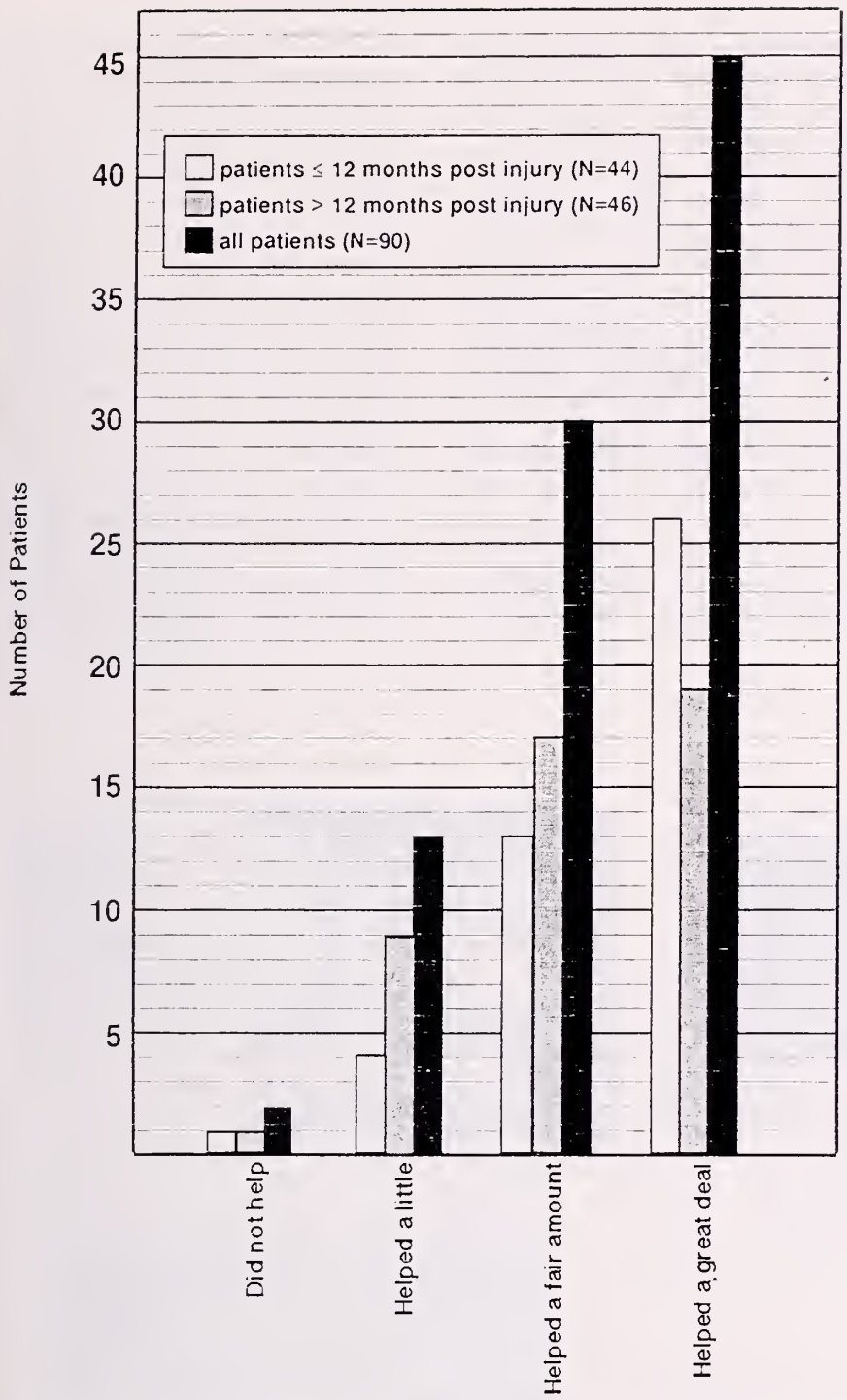

Fig 3.-How much do you feel the program helped you learn how to cope with and manage your pain?

jury.

Return to work results are displayed in Table 2. Of those not working at the time of their initial evaluation (n=47), 75% (n=35) reported either a return to work (n=29) or current involvement in a retraining program (n=6). Out of the 29 who had returned to work, only four were not employed at the time of the survey (all of these four, however, had been working at some time during the six months prior to the survey). A chi-square analysis of the data in the table, comparing patients who never returned to work with those who either were in retraining or had returned to work, shows that significantly more patients in these latter groups were likely to return to work if they were referred early ($X = 5.88$, $p = 0.015$).

Discussion

Many of the issues surrounding chronic pain management outcome studies have been comprehensively reviewed recently in a three-part series by Turk and Rudy.[2-4] One of the issues they discuss is percentage of patients available at the time of followup, noting that it is not unusual for follow-up evaluations to be based on less than 30% of the original population treated. Our response rate of 65%, then, compares favorably. Our overall number of responses (n=91) was greater than the average number of responses reported by Flor et al[5] (n=61) in a recent meta-analysis of 65 chronic pain outcome studies.

Controversy exists regarding the meaningfulness of patients' pain improvement reports, and wide variations in outcome results have been reported.[2] Indeed, in a behaviorally based or operant pain program similar to that introduced by Fordyce[6] subjective pain improvement is not emphasized. In our experience improvement in pain symptoms is an attainable goal as evidenced by the fact that 93% of patients reported improved pain level between the beginning and end of their program. We attribute this high success rate to (1) the customized program development for each patient, (2) the aggressive but selective use of medications and therapeutic injections used in conjunction with other therapies, (3) the experience level of the staff in comprehending both the biophysical as well as psychosocial aspects of chronic pain, and (4) the quality of teamwork, including involvement of the patient as an active team member.

Even more significant than pain improvement at the time of discharge is maintenance of improve-

ments over time (Figure 2). Approximately one out of five (19%) patients responded that their pain level had remained about the same since discharge, and nearly three out of five (57%) reported even further improvement since discharge. The reasons for pain improvement after discharge are not clear. We would theorize that at least in part it is due to the patient consistently performing exercises and practicing coping techniques learned during treatment.

An important finding in Figure 1 is that a patient's pain is infrequently cured or improved "100%" upon program completion; only two out of 91 patients reported "100%" improvement in our study. We discuss this issue with the patient from the beginning of the program. We feel that a major emphasis of the chronic pain treatment and management program must be not only minimizing pain but also educating the patient in ways to cope with and manage residual pain. Ninety-eight percent reported that the program helped them to learn how to cope with and manage their residual pain.

Finally, a major goal of our program is safe, successful return to work. Three out of four patients who were not working at the time of their initial evaluation returned to the work force or were currently in the process of job retraining. Simply reporting the number of patients who returned to work may be misleading, however, as the return to work may have been for only several weeks or months immediately following program completion. More important is whether the worker is still actively employed several years later. In our study 25 out of 29 patients who returned to work were still working at the time of the survey, and those four patients who had returned to work but were not working at the time of the survey all reported that they had worked at some time during the previous six months.

Patients are frequently referred to our clinic after one or more failed attempts at return to work. In our experience common reasons for repeated failure to return to work include the following: (1) premature

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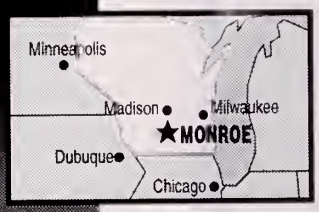

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When comparing responses of patients referred early (≤ 12 months after injury) to those referred later (>12 months after injury), several interesting points arise. Overall those referred early reported a slightly greater percent pain improvement at the time of program discharge and were significantly more likely to have returned to work. Both early and late referral groups, however, were equally as likely to report maintenance or improvement of pain level over time, and both groups found the program equally useful in learning coping skills.

Based on the data reported in this study we believe that the interdisciplinary chronic pain treatment and management approach to the injured worker is effective for the majority of patients and that early institution of such a program enhances outcome.

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Extracorporeal circulation and open heart surgery

Ronald D. Nichols, BS, CCP; Edward L. Murray, CP; and Charles C. Canver, MD, Madison

Appreciation for the importance and the function of the human heart dates back to the early speculations of the Greeks Aristotle, Plato, and Galen. However, little advancement was made until William Harvey devoted a significant portion of his life to understanding the normal functions of the heart.[1] He was the first to describe the significance of the cardiac valves and those in the peripheral veins. The concept of unidirectional flow with the heart pumping blood to the lungs and the body was described by him. These facts represent the basics for the workings of the modern heart-and-lung machine. The repair of traumatic damage and the correction of physiologic consequences caused by congenital defects required surgical intervention; however, no progress in this field was made until after the introduction of the effective use of anesthesia in the 1840s[2] and the recognition of the importance of sterile technique.

A variety of innovative approaches to extracorporeal circulation have been made over the last century. The first true heart-and-lung machine that allowed oxygenation of the circulating blood without interrupting the blood flow was developed in 1885 by von Frey and Gruber.[3] Among the early investigators, the most famous pair to try to apply the concept to humans was the Nobel Prize winning Alexis Carrel and Charles Lindberg.[4] They developed a practical bubble oxygenating column that was quite acceptable for simulating lung function. Research continued on many fronts with ingenious approaches to heart disease without the use of a machine; investigators employed shunts, inflow occlusion for short periods, and even cross-circulation using another person as the temporary heart-lung support.[5]

In 1953, the first successful human application of a heart-lung bypass machine became a reality when a pump oxygenator, developed by John and Mary Gibbon, was used to repair an atrial septal defect.[6] The advent of coronary arteriography[7] stimulated the development of the coronary artery bypass grafting procedure to restore the blood supply of the distal myocardium beyond the critical coronary artery stenoses. Coronary bypass conduits, the internal thoracic artery and greater saphenous vein, were described late in the 1960s.[8] In all of the experimental developments, careful control over the process was crucial to the reproducibility of results. The researchers were the forerunners of today's perfusionists who are charged with maintaining a controlled environment to enhance the safety of the open heart procedure. The time has come to recognize this profession in more detail and to set some limitations as to who may practice within an acceptable framework. This article reviews the basic components of an extracorporeal circuit and looks at the role of a perfusionist in open heart surgery.

Cardiopulmonary Bypass Circuit

The primary function of a heart-lung bypass machine is to withdraw the patient's blood, extract carbon dioxide, replenish oxygen, and return the blood to the patient, under pressure, simulating the function of native lungs and heart. The major components of a typical circuit are:

Venous Cannula. Extracorporeal circulation begins when blood is drained from the patient via the siphon effect through a cannula inserted into the right atrium with the tip extended into the inferior vena cava. The cannula has multiple holes at the tip and at the right atrial level to promote drainage. A primary characteristic found with a quality cannula is its resistance to kinking, conferred by wire reinforcements imbedded into the wall of plastic or other biocompatible materials. The length of the cannula must be adequate to drain the blood upward and out of the chest. The venous cannula is connected to large-bore (1/2-inch internal diameter) tubing that conveys blood toward the heart-lung bypass machine. The large tubing minimizes impedance to blood flow and distinquishes it from other tubings in the circuitry. Blood drained from the right atrium is oxygen-depleted. Measurement of circulating blood oxygen saturation[9] or the partial oxygen pressure (pO_2)[10] allow determination of the adequacy of the oxygen supply reaching the body. Modern monitoring devices can determine these values rapidly and inexpensively when they are placed in the venous tubing.

Venous Reservoir. The venous reservoir provides space for blood volume fluctuations that often occur during extracorporeal circulation. These can be caused by temporary impedance to venous flow, addition of fluid into thesystemic circulation, or changes in the systemic vascular resistance. Most reservoirs accommodate at least one liter and some hold up to four liters of blood. These

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reservoirs may be either soft and flexible or hard and rigid. Our preferred type contains a filtering material normally present in the cardiotomy reservoir.

Cardiotomy Reservoir. The cardiotomy reservoir is used to filter and debubble all shed blood from the surgical field and vented blood from the aortic root or left ventricle. It also serves as a convenient spot for the administration of intravenous solutions, blood, or drugs. When the cardiotomy reservoir is used as a separate unit, the blood drains from it and enters the venous reservoir.

Arterial Pump. In most perfusion circuits, the blood leaves the reservoirs and passes through the arterial pump, the "artificial heart." The pump that is utilized for the relatively short time of a bypass procedure is one of two types. The traditional roller pump has a piece of blood tubing compressed by one or two rolling cylinders that move inside of a solid curved wall. The revolutions of the rollers and the size of the tubing determine the velocity of the blood flow. The constrained vortex or centrifugal pump operates by propelling thin layers of blood forward by spinning the innermost surface of the device at high speed. The velocity of flow depends on the rotation of the pump and the downstream resistance. Because of the fundamental differences in the way the pumps work, if an impediment to flow develops, the roller pump will increase the pressure downstream until something gives—a blood-to-air leak or a dissection of the aorta—whereas, with the centrifugal pump, the forward flow will simply cease. The result of an aortic dissection from this cause may well be fatal. This safety concern has caused many to use the more expensive centrifugal pump. However, there is little convincing evidence that either one is better than the other with regard to potential damage to the blood.

Both roller and centrifugal pumps may be used in a pulsatile mode. This is theoretically more physiologic and should provide better peripheral perfusion. The primary problems have been to duplicate a normal blood pressure wave form and then to show that any advantage exists for using this pulsatility. Reproduction of a physiologic arterial wave form may be an appealing option. Special care, however, must be taken to avoid excessive gradients across the aortic cannula tip as a result of the rush of blood at the height of the pressure wave. The best solution is to place a cannula with a larger orifice, although this may be less desirable than the presumed benefit of pulsatile flow. To date, no convincing argument has been made to justify the use of pulsatile flow.[11]

Oxygenators. The membrane type of oxygenator is currently the most commonly used. Oxygen and carbon dioxide diffuse directly across the membrane instead of the oxygen bubbling through a column of blood, as was the case in the earlier bubble oxygenators. The membranes are considered to be less damaging to the blood[12] and undoubtedly allow less microembolus creation than did the bubblers. Many membranes are available on the market today and the better devices have low priming volumes, high gas-exchange rates, good built-in heat exchangers, excellent biocompatibility, and low blood-pressure gradients, and are designed to prevent air from forming on the blood side or from exiting the device. Contemporary membranes are generally considered very adequate temporary substitutes for the human lung.

Arterial Blood Filter. From the oxygenator, the blood passes through the arterial blood filter. Originally, the filter was used to capture microemboli that were present, primarily in banked blood. The use of bloodless primes and controlled hemodilution of the patient's own blood have, however, reduced this source of emboli. Better understanding of the presence of microemboli in the circuit retained from the assembly and manufacture of the disposable components[13] has led to the use of prebypass filters to minimize the amount of circulating particulates before the onset of bypass. It is well known that microemboli exist in IV solutions[14] and that, if they are filtered appropriately, the counts diminish. There was also a poor understanding of adequate anticoagulation in earliest years and arterial filters were used as a way to catch and remove the first aggregated clumps of new clots. With current technology, it is possible to know that adequate anticoagulation has been achieved and so this is less of a concern.

The most beneficial use of the arterial filter is to remove microair and macroair emboli. Microair can be multioriginated and is especially insidious, for it is hard to visually detect because of the small size of the particles. It is most dangerous when the particles are continuously being produced. Macroair is a sudden large bolus of air that usually comes from overpressurizing the circuit or running the venous reservoir completely empty. Indeed, a recent study revealed the incidence of macroair as 0.11% with over 375,000 operations.[15] Despite the low rate of occurrence, its consequences to the patient can be catastrophic. A properly functioning arterial filter should be ableto prevent the passage of any of these particles.

Arterial Cannula. Oxygenated blood is usually returned into the distal ascending aorta or one of the common femoral arteries. The arterial line (3/8-inch internal diameter) is distinct in size from other tubings in the field. The choice of an arterial cannula varies widely among cardiac surgeons. The shape of the cannula tip can be straight or acutely

angled. The tip can be short or long. The external and internal diameters might be large or small at the point of entry. A preferred cannula has a tip that is curved enough to send the blood into the central aorta and has a thin metal wall to maximize the flow potential for the size of the hole that needs to be created in the aorta. The exact amount of flow that may pass through a given cannula before the pressure gradient across the tip causes blood damage remains controversial.[16,17]

Miscellaneous Lines. Multiple small (1/4-inch internal diameter) tubes in the operating field are used for scavenging shed blood, venting of cardiac chambers, or delivering cardioplegia solutions. Extreme care is always necessary in the placement of these tubings into the individual pumping chambers to prevent catastrophic complications.

The Perfusionist

The perfusionist is responsible for the entire extracorporeal circuit, from creating the circuit design, procuring disposable components, and assembling the devices, to maintaining the sterility of the setup. Prebypass safety checks are now routine to ensure that the pump is totally operational before the onset of extracorporeal circulation. The perfusionist usually handles pharmacologic interventions, fluid and blood administration, and control of blood pressure and flow. Documentation of all interventions are made on a perfusion record, which is incorporated into the patient's medical record.

The American Society of Extra-Corporeal Technology has created a Scope of Practice[18] to delineate what a perfusionist may be responsible for. In addition to the standard heart-lung machine, the perfusionist may also operate several types of ancillary equipment such as cell-washing devices, ultrafilters, intra-aortic balloon pumps, blood-flow monitors, and other laboratory machines. Blood-gas analyses and clotting studies are useful when done quickly and near the patient. Quality assurance documentation is required along with preventative maintenance records for each piece of equipment. A heart-lung bypass machine, managed by a competent perfusionist, is a crucial element in the successful outcome of a cardiac operation.

Perfusionists have come to the profession from many walks of life and many were originally trained "on the job." As the number of heart surgery procedures and the complexity of the perfusionist's role has increased, there was a need and a desire to establish formal training centers. Currently, practicing perfusionists and many other health professionals believe entry into the field should be limited to those that have graduated from an accredited college perfusion training program. There are, however, no regulations covering the profession, except in Texas and California. The Wisconsin Perfusion Society has attempted to guide a bill through the Wisconsin State Legislature that would require minimal standards be met before one could operate a heart-lung machine. This bill has yet to become law. A current listing of all accredited perfusion schools in the United States may be obtained by contacting the American Board of Cardiovascular Perfusion at (601) 582-3309.

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Gov. Thompson signs tort reform into law

THE NEW PRESIDENT of the State Medical Society of Wisconsin witnessed May 10 the governor's signing of a bill to limit non-economic damages awarded in medical malpractice lawsuits, calling the action "a giant step in medical malpractice insurance reform."

The newly elected Republican majority passed the $350,000 cap on non-economic damages as part of its initial 30-day legislative blitz. The bill's author, State Rep. Mark Green (R-Green Bay) spoke on the benefits the cap will have in obstetric shortage areas. Other legislators who attended included Representatives Frank Urban, MD, (R-Brookfield), and Scott Walker (R-Wauwatosa) and the Senate author Sen. Joanne Huelsman (R-Waukesha).

Approximately 50 physicians, medical students, SMS and Medical College of Wisconsin staff attended the bill signing ceremony. In his remarks, the governor indicated that

Continued on next page

A GIANT STEP FOR MEDICINE. Gov. Tommy Thompson signed a major tort reform bill into law May 10, capping numerous years of work by SMS staff and concerned others. Among those witnessing the signing were: the bill's co-authors, state Rep. Mark Green (R-Green Bay) and Rep. Joanne Huelsman, (R-Waukesha), both seated; Rep. Frank Urban, M.D. and SMS President Marcia J.S. Richards (behind Huelsman); (from Richards to the right) Mike Kirby, SMS director of governmental relations; Raymond Zastrow, M.D., chair of the SMS Board of Directors; and SMS Executive Vice President Thomas L. Adams, CAE. About 50 physicians, medical students and residents attended the May 10 signing ceremony.

Continued from preceding page
he thought the bill would hold up to any challenges in the court system. He also stated that the cap will help control health care costs by limiting the rising cost of medical liability insurance for providers and it will allow physicians and hospitals to practice less defensive medicine. Over a five-year period, the cap is expected to save between $50 to $60 million for the state's Patients Compensation Fund, reducing what physicians will pay into the fund by an average of 11%.

SMS President Marcia J.S. Richards, MD, of Milwaukee, greeted the new law as "good medicine" for Wisconsin. "By setting limits that will allow actuaries to better predict claims statistics," she said, "physicians will begin to see some decreases in medical malpractice premiums."

"Today we mark this giant step in medical liability insurance reform, hoping it will result in the promised eased burden on the state's physicians and patients. We owe a great debt to Republican leaders who made this issue a key point of their legislative blitz. And we intend to pay that debt back with a renewed belief in our ability to strengthen and implement health system reforms that ensure every Wisconsin resident has access to quality, cost-effective care," Richards said.❖

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A presidential attempt at tort reform, 1989-1990

William Treacy, MD, Waukesha

When I was serving my year as president-elect under the capable tutelage of JD Kabler, MD, many people asked what I wanted to accomplish during my year as president of the SMS. I really had not considered it in those terms, thinking I would just deal with the issues that would come up and try to communicate the reasons for our position on these issues to our membership as best I could. However, upon thinking about it and considering the importance of liability issues to physicians, my experience as Board chair of WISPAC, my many experiences on the Liability Committee and the newly forming physician-owned malpractice insurance company PIC Wisconsin, I decided in my own mind to focus on getting a tort reform bill passed as a primary objective of my year as president.

As the summer of 1989 began, I noted that little or nothing had been attempted during the budget bill session along these lines. I pointed this out to Tom Adams--probably a bit more forcefully than was needed which it seems is so often my way. Tom responded differently from what I expected in that he agreed with me and encouraged me to carry this idea to Terry Hottenroth and Bill Broydrick who then was our contract lobbyist on this issue. I did this and our meetings, I think, were very productive. They pointed out the problems with getting a $250,000 cap on non-economic awards passed, of which I was well aware. Getting it through the Democratic-controlled Legislature would be no small task considering the chairs of the committees to which the bill would likely be referred by the leadership were staunch allies of the trial attorney lobby.

We decided the only reasonable chance we had at passage of this bill would be to attempt to mobilize grass roots physician contacts with both the Legislature and the governor. I mentioned this in every contact I had with physicians at county

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Continued from preceding page
medical society meetings, etc. Terry Hottenroth did the same in her physician contacts. Bill Broydrick did, I feel, a particularly good job of this and increased the number of contacts he had with physician groups. He had a wonderful way of explaining how to effectively get our ideas across to legislators. He was also very good at motivating physicians to do so, pointing out, among other things, that this was the only way to get what seemed to be an impossible task done.

By early fall 1989, the effect of some of all this was beginning to show. The Tom Haukes and the Lynn Adelmans were still just as immutable, but some other legislators and the governor were beginning to respond to some of the messages they were getting. The governor let it be known that he was impressed by the number and the quality of the letters and other contacts he was receiving from physicians. We met with the governor again and suggested he call a special session of the Legislature to address this issue. In a special session, the rules controlled by the majority party would not be so devastating to us. He took this under advisement, which we appreciated greatly.

The governor called a special session of the Legislature in December 1989 to address not only medical liability issues but also a number of other issues as well. Not a whole lot happened during that special session, but I sensed that physicians were more willing to address their legislators after that having seen some effect of their efforts.

During the legislative session in early 1990, our efforts at making progress on tort reform in the legislative process were continually thwarted by our opponents in key positions in both the Assembly and the Senate. By about March of 1990, however, we were again hearing from the governor about the number and quality of contacts he was receiving from physicians on the tort reform issue. We learned to never underestimate the potential of physicians when they set their mine to something. Terry, Bill, and I continued our efforts to encourage physicians to make their voices heard.

Shortly before the 1990 SMS annual meeting, we heard from the governor that he was considering calling another special session to address medical liability issues. He also let it be known that he would be happy to sign a bill that we supported on another medical issue at our upcoming annual meeting in Green Bay. I hoped that calling a special session and his appearance at our annual meeting might be related but they clearly were not.

My year as president of the SMS ended without a tort reform bill being passed, but I feel there are two lessons to be learned from all this. First, tort reform in the form of a significant cap on pain and suffering awards is a viable idea that of which legislators can be convinced. Second, a few well-positioned legislators can effectively block the passage of any good idea into law.❖

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Searching for words to describe the moment

Terry Hottenroth, JD, Madison

"Medical Liability Reform Wins Legislative Approval." "Governor Signs Tort Reform Bill." "Doctors and Patients Win, Lawyers Lose." Ever since it became apparent that medical liability reform would finally be taken up for legislative debate and action this spring, I've found myself trying out snappy headlines as a sort of shorthand description of this journey. Now, as I write this, Assembly Bill 36 sits on the governor's desk awaiting his signature, and I'm struck by the inadequacies of my headlines when it comes to conveying the significance of the product and the process which yielded it.

Passage of this legislation symbolizes many things to physicians, I think, and to those of us who are privileged to represent them. First, of course, it represents at least a partial solution to the problem of out-of-control liability premiums and the resulting effects on health care costs and access in our current system. But beyond that, it also represents a moral victory as well as a political victory--a vindication for physicians in the sense that, for many of them, passage of this legislation says that the Legislature finally listened to them, finally took their concerns seriously, finally acknowledged the problem, and finally agreed to try the solution suggested by the people on the front lines. (Sounds like Total Quality Improvement in action, doesn't it?)

Passage of this legislation also shows the importance of conviction, tenacity, and commitment. I worked on this issue for a decade; many of you readers worked on it for far longer, as did many others who are no longer with us. I believe strongly that all of the effort expended before this legislative session was instrumental in building the necessary legislative and public support for passage this time around--and in making this a priority for the new legislative leadership. People don't become converted to a cause like this overnight, especially when they're in the Legislature, despite the fact that to us the merits of our position are self-evident. Ultimately, victory was possible because of the State Medical Society members' commitment to keeping this issue constantly before the Legislature and the public, so that it was seen as something worth fighting for.

The change in party control of the Legislature, from Democrats to Republicans, was the pivotal factor in passage of this legislation, not because only Republicans support liability reform--many Democrats have been stalwart supporters as well--but because the issue has a partisan life of its own whereby it becomes a sort of rallying point, a line drawn in the sand on either side of which our two major political parties and their traditional allies cluster. Many physicians, independent and non-partisan by nature, find this hard to understand: Why should party leadership exercise this type of control, why should factors other than the simple merits of the arguments play such a strong role? Over the years, I too experienced the frustration embodied in these questions, to which there is no good answer--only an acknowledgement that that's the way it is. Some of this has to do with sources of money and political power; some of it has to do with deeply held convictions that to us may be ill-informed or misguided, but are real and right to their owners.

Unfortunately, focusing on the partisan nature of this issue tends to obscure the individual contributions of many legislators from both political parties. I have great respect for those Democrats who swam against the tide and sought for years to get action on this legislation. Likewise, I have great respect for the Republican legislators in both houses who in both houses who cared enough to make this issue one of their top priorities. Thanks are due to both groups of legislators.

Turning our gaze inward, there are a few other object lessons that come to mind as we contemplate this achievement. First, persistence pays. Few organizations could sustain the depth of commitment that SMS showed on this issue year after year. The organization's ability to stick with a position despite adversity, and to opt for long-term benefits rather than short-term success, was key in bringing us to this point. (I remember well the difficult decision made by the SMS leadership some years back to forego a chance that was offered to reinstate a $1 million cap--something that left many of our legislative champions shaking their heads in awe at our foolishness--because we reached the conclusion that reinstating that cap would make it far less likely that we would ever obtain a lower one, and the short-term benefits simply didn't justify the long-term opportunity costs. In retrospect, that decision was

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Terry Hottenroth served as lobbyist and director of public affairs for the State Medical Society from 1984 to 1992, and since leaving the SMS has continued to work on the Society's behalf as a contract lobbyist. She is part of the government relations team at the law firm of Whyte Hirschboeck Dudek, S.C. and will receive her JD degree in August 1995, after which she will practice health law in addition to government relations. She recently authored an article published in the *Wisconsin International Law Journal*, "Lessons from Canada: A Prescription for Medical Liability Reform."

Continued from preceding page
correct.)

Also key was the commitment of many SMS presidents and other physician leaders, whose determination and tenacity kept us, as staff, going when it would have been easier to back off from this issue. They challenged us to do everything possible (and sometimes things that felt impossible), but never asked for as much as they gave themselves.

Second, in a battle of this magnitude, some injuries from "friendly fire" are probably inevitable. We incurred them and learned how to deal with them. The positive side is that such occurrences serve as a reminder of the importance of the issue to the organization's members, and show that SMS members are not passive bystanders but are deeply engaged in issues of great importance to the Society.

Third, it is unfortunate but true that after two-plus decades of public discussion and scholarly research about our medical liability "system," there remains a deep gulf between physicians and lawyers as a group, shown in part by the vastly differing responses of their respective professional organizations to the basic question of whether there is a problem in the tort system's handling of medical liability issues. As with political partisanship, however, viewing this as a doctor-v-lawyer fight over-simplifies and obscures. The chief authors of AB 36, who also led the floor fight on the bill in each house, are attorneys; the Assembly speaker who made this issue one of the leadership's top priorities is an attorney; many of the Democratic legislators who have long supported liability reform are attorneys. Perhaps the lesson is that we must find common ground one person at a time. It's curious, however, that in other countries--Canada comes to mind--physicians and attorneys collectively seem to have much more commonality in their perception of liability issues and are somewhat bemused by the fierce controversy over these issues in the United States.

So now that AB 36 is passed, what next?

First, thanks and kudos to those past and present legislators who made it possible, and to all within the SMS family who helped bring it about.

Next, graciousness in victory, and a recognition that at least some members of the opposition truly believe their own rhetoric. Don't cast out those whom we've not yet converted.

Third, avoid painting with too broad a brush when identifying "friends" and "enemies" on this issue. The categorizations are not nearly as simple and clean as they might appear at first blush.

Last, and most important, don't expect miracles from the passage of this legislation, and let this be a beginning as well as an end. Passage of AB 36 is an enormously significant step that will benefit patients, not just doctors. But its effects will not be fully felt immediately, and it will not solve every problem that exists today or will come into being in our liability system. After a much-deserved breather, the SMS should roll up its sleeves and go back to work on some of the other areas where the medical liability system cries out for improvement.

Thanks for letting me travel with you on this momentous journey.❖

MUCH CREDIT for the passage of AB 36 goes to the SMS lobbying team. Lobbyists worked long hours to make sure representatives had the information they needed to support the legislation and answered numerous questions about the bill. Pictured are: (from left) SMS Corporate Counsel Mark Adams, J.D., along with Kathy Anderson, Government Relations Director Mike Kirby, and Colleen Wilson, J.D., all of the SMS lobbying team.

An interview with David Prosser

Shari Hamilton, editor

When the state Legislature passed a bill in the mid-1980s setting a $1 million indexed cap on non-economic malpractice damage awards, Rep. Dave Prosser thought the action was "ludicrous" so the Appleton Republican voted against the bill.

This session Prosser, who is now speaker of the Wisconsin Assembly, succeeded in passing through the most extensive tort reform our state has seen, a bill that contains a $350,000 indexed cap on non-economic damages.

Those two actions may seem contradictory, but to Prosser, they're not. In a recent interview with the WMJ, the Wisconsin speaker discussed his views on tort reform and health care reform, past and present.

ASSEMBLY SPEAKER Dave Prosser looks up from the ream of papers associated with AB 36. Prosser played a key role in ensuring the bill was passed during the Republican leadership's 30-day blitz.

Prosser's perspective on tort reform's history

As a member of the Joint Committee on Finance from 1980 to 1988, Prosser said he could not in good conscience vote for the $1 million damage award cap proposed, and later passed by some of his colleagues.

"When you have these caps or ceilings, it's something to shoot for," he explained. "(The cap) would go up every year according to the consumer price index. I thought if you were going to have a cap, you should have a much lower cap or you shouldn't have anything at all."

Prosser said that when the legislation passed he thought the $1 million cap was "something that would very quickly be viewed as a mistake."

"And I don't think there's any question that that's what happened," he added, referring to the cap's short life span before the provision sunsetted.

The Wisconsin speaker observed that when a state has a high cap or no cap, health care providers seem to have to cover themselves for any circumstance that would allow a payout that reaches that cap.

"The system cannot require every provider to insure for the moon," Prosser said. "The cap provides some certainty; it provides some stability."

Prosser supports indexing that allows for payments to go up as the cost of living rises--a provision that is included in the new tort reform law.

30-Day promise

Wisconsin doctors are well acquainted with the Appleton Republican's commitment to tort reform, having heard him speak at various county medical society gatherings.

Prosser explained why it was so important for this "symbolic act" during the first month of Republican leadership.

"To me, we were not simply picking any bill with a promise to act on it within 30 days. We were picking a bill that had been deliberately bottled up and prevented from consideration by the full Assembly," Prosser said.

The speaker noted that he has talked before--often and publicly--about what he believes was the barrier that prevented the full Assembly from taking on tort reform. The past leadership of the Assembly,

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Prosser said, "had been bought off--not in terms of personal corruption but in terms of political contributions."

"I think the Wisconsin Academy of Trail Lawyers had provided so much money to Assembly Democrats that they (Democratic lawmakers) were beholden to them and had promised them never to act on the bill--never to act on tort reform, irrespective of how manymembers wanted to take action."

The speaker stressed that he never wants to discover himself in the same place. "I personally do not want to become so beholden to a group, no matter who they are and no matter how much I tend to agree with them, that I feel a monetary obligation to hold their views," the speaker said.

Controlling costs, improving access

Prosser said he regards the priorities for health reform in Wisconsin as addressing quality, access and cost. But right now, he is particularly interested in controlling costs, especially those associated with tort suits, defensive medicine and health care fraud and abuse.

The new tort reform law, Prosser said, is also designed to hold down costs by reducing the need for defensive medicine.

"It's in the interest of the public at large to hold down costs. Doctors shouldn't do 10 tests when two will do," he said, suggesting that reducing paperwork would be another means of limiting costs.

SMS initiatives on tort reform

As top Assembly Republican, Prosser views SMS lobbying as instrumental in the passage of this tort reform initiative. "The State Medical Society has been quite effective informing members (of the Legislature) about the nature of this problem, and the need to address tort reform," he said.

Prosser also noted that for about one-third of the lawmakers, tort reform was a new issue, one they had never cast a vote on before.

Tort reform's future

The success of this tort reform measure will be gauged in studies to be done by the Office of the Insurance Commissioner, but Prosser said he and other lawmakers will be watching the medical establishment closely.

"If rates don't go down, believe me, (this law) will be revisited," he said. "If providers and insurers have limited damages, and the public doesn't see relief, then why should we limit damages?"

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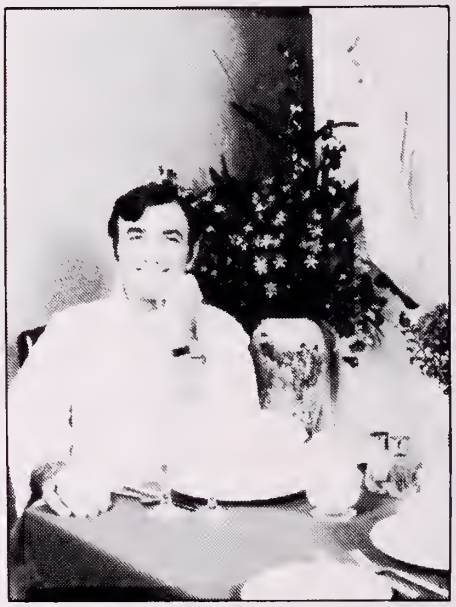

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The costs of cigarette smoking to Wisconsin's Medicaid program

Linda Watson, MA; Richard Yoast, PhD; Susan Wood; and Patrick L. Remington, MD, MPH, Madison

THE HEALTH AND economic costs from cigarette smoking are substantial. A national study estimated that $50 billion in medical care expenditures were attributable to cigarette smoking in 1993.[1] In Wisconsin, cigarette smoking is the leading cause of death, claiming more than 8,700 lives annually.[2] A recent study published in the *Wisconsin Medical Journal* estimated that cigarette smoking in Wisconsin accounted for approximately $1 billion annually in health care costs.[3] The purpose of this study is to identify state Medicaid program direct medical care expenditures that are attributable to smoking.

Background

Medicaid is a means-tested entitlement program that provides health care coverage to certain low-income and disabled persons for medically necessary services furnished by qualified providers. Individuals can become eligible for Medicaid several ways. Of the 468,000 Wisconsin Medicaid recipients for 1993-1994, 64% were eligible because of their eligibility for aid to families with dependent children, 18% were blind or disabled, 11% were aged, and 7% were others who were eligible through "A Healthy Start" initiative for children and pregnant women, the relief program for needy Native Americans, or as qualifying refugees.

The costs of the Medicaid program are shared by the state and federal government. In Wisconsin, total Medicaid program expenditures for the 1994 fiscal year were $2.2 billion. Of this, approximately 40% ($835 million) came from state funds, representing approximately 15% of the state's annual budget.[4]

Methods

For this study, we estimated direct health care costs related to smoking under the state's Medicaid program using information obtained from the Electronic Data System (EDS) Corporation. EDS was the Bureau of Health Care Financing's fiscal intermediary for Medicaid claims processing during the time of this study, July 1, 1993 to June 30, 1994.

Disease-specific cost data were obtained from the fee-for-service claim forms for persons in the fee-for-service program. Smoking-related health care costs were not estimated for the 150,000 persons enrolled in the Wisconsin Medicaid HMO program, since providers are paid on a capitation basis and not from claims.

Direct health care costs due to smoking were defined as health care expenditures for the prevention, treatment, and rehabilitation of smoking-related diseases. Various methods have been established to determine provider reimbursement levels for the provision of Medicaid covered services. Under fee-for-service, the providers are paid the lesser of the "usual and customary" charge or the Medicaid maximum allowable fee.

In collecting the fee-for-service paid amounts, the EDS categorized the data by the International Classification of Disease (ICD-9) codes and type of service delivery. Fee-for-service reimbursement formulas vary according to the type of service rendered. For example, hospitals are paid by category of service (eg, radiology, laboratory, etc), whereas skilled nursing facilities are paid by the level of care provided (eg, skilled, custodial, etc). We used the following steps to collect the data from the EDS for persons enrolled in the fee-for-service Medicaid program.

First, smoking-attributable costs were derived by reviewing the 1994 claims submitted to EDS for smoking-related illnesses listed as "primary diagnosis." These diagnoses reflect all ICD-9 codes identified in the Smoking-Attributable Mortality, Morbidity, and Economic Costs (SAMMEC), version 2, computer software, developed by the Centers for Disease Control and used to estimate the disease effects of smoking on a given population.[5] Each ICD-9 code was grouped by disease category (eg, respiratory illness, neoplasms, etc). Perinatal conditions occur in individuals under 1 year of age.

Second, total costs attributable to smoking were calculated by combining the totals for each diagnosis, multiplied by the appropriate smoking-attributable fraction (SAF). Each fraction was estimated from diagnosis-specific relative risks and smoking prevalence rates as formulated by the SAMMEC model. For example, 83% of the costs from treat-

From the Bureau of Public Health, Wisconsin Division of Health. Reprint requests to Patrick Remington, MD, MPH, Wisconsin Division of Health, 1414 E Washington Ave, Room 251, Madison, WI, 53703-3041. Watson is a graduate student with the University of Wisconsin-Madison Programs in Health Management. Dr Yoast is the director for Project ASSIST, the state's tobacco control program. Wood is the section chief for Chronic Disease and Health Promotion. Dr Remington is the chief medical officer for Chronic Disease Control, Bureau of Public Health. Copyright 1995 by the State Medical Society of Wisconsin.

Smoking-related direct health care costs (in thousands), Wisconsin Medicaid program, 1994.

Smoking-related disease	ICD-9 code	Total Medicaid expendi-tures**	SAF*	Medical costs attrib. to smoking**
Respiratory illness:				
Respiratory tuberculosis	010-012	$ 7,195	29%	$ 2,086
Pneumonia, influenza	480-489	$ 19,322	25%	$ 4,830
Bronchitis, emphysema	490-492	$ 23,820	80%	$ 19,056
Asthma	493	$ 15,101	23%	$ 3,473
Chronic airways obstruction	496	$ 15,101	80%	$ 12,081
Subtotal		$ 80,540		$ 41,526
Cardiovascular disease:				
Rheumatic heart disease	390-398	$ 5,310	15%	$ 797
Hypertension	401-404	$ 3,181	15%	$ 477
Ischemic heart disease	410-414	$ 59,006	19%	$ 11,211
Other heart disease	415-424	$ 65,027	17%	$ 11,054
Cerebrovascular	430-438	$100,235	15%	$ 15,035
Atherosclerosis	440	$ 1,693	35%	$ 592
Other arterial disease	441-448	$ 2,292	41%	$ 940
Subtotal		$236,744		$ 40,106
Neoplasms:				
Lip, oral cavity, pharynx	140-149	$ 878	76%	$ 667
Esophagus	150	$ 530	73%	$ 387
Pancreas	157	$ 332	22%	$ 73
Larynx	161	$ 1,455	78%	$ 1,135
Trachea, lung, bronchus	162-179	$ 30,327	83%	$ 25,171
Uterine cervix	180	$ 909	27%	$ 245
Bladder	188	$ 1,221	38%	$ 464
Kidney, other urinary	189	$ 937	32%	$ 300
Subtotal		$ 36,588		$ 28,442
Perinatal conditions:				
Low birth weight	765	$ 4,632	16%	$ 741
Resp distress syndrome	769	$ 1,061	17%	$ 180
Resp condition newborn	770	$ 2,641	15%	$ 396
SIDS	798	$ 32	11%	$ 3
Subtotal		$ 8,366		$ 1,320
Smoking cessation costs:				
Nicotine patches		$ 1,080	100%	$ 1,080
Nicotine gum		$ 68	100%	$ 68
Subtotal		$ 1,148		$ 1,148
Burn-related injuries:				
	940-949	$ 1,683	25%	$ 421
Subtotal		$ 1,683		$ 421
Total Medicaid expenditures				$112,962

*SAF equals smoking attributable fraction, from SAMMEC, 1992 (see reference 5)
**Times one thousand. Numbers may not add due to rounding.

ment of lung cancer are attributed to smoking.

Third, Wisconsin's Medicaid program provides reimbursement for nicotine patch and gum therapy. These costs are directly attributable to smoking, and were added at 100% to the other (disease) totals.

Results

Total Medicaid costs attributable to smoking are estimated to be $112,962,000 (Table). Respiratory illnesses are responsible for 37% of these expenditures with $41,526,000 of the total costs. Cardiovascular diseases account for 36%, with $40,106,000, neoplasms for 25%, with 28,442,000.

Discussion

The health care costs spent on treating cigarette smoking-related diseases for persons in Wisconsin's Medicaid Program exceeds $112 million annually, representing about 5% of the state's $2.2 billion Medicaid expenditures. This is similar to a national study that found that approximately 5% of total US Medicaid expenditures were attributable to cigarette smoking (Thomas Novotny, personal communication).

The smoking attributable costs described in this report are underestimated for several reasons. First, smoking-related costs for the one third of Medicaid recipients enrolled in HMOs are not included because disease-specific information is not available in the claims history for this time period.

Second, the epidemiologic model of attributable risk used to measure the effects of smoking assumed smoking rates that were similar to the general population. In fact, studies have shown that persons on Medicaid are twice as likely to smoke, compared with the general population.[5] By incorporating such Medicaid-specific smoking prevalence data, the smoking attributable fractions would be higher.

Third, our estimates did not include most pharmaceutical costs.

Aside from costs incurred through the use of nicotine patch therapy, we were unable to identify the costs of prescribed medications for treatment of smoking-related diseases.

Finally, these data reflect only the direct costs attributable to smoking. The health costs from passive smoke are not included. Indirect costs of smoking include the value of the income or productivity lost when smoking-related illness and death result in time away from work and other productive activities. To the extent to which the disease results in disability and loss of income, individuals turn to Medicaid to cover their medical needs, which increases caseload and costs. Furthermore, intangible costs, such as pain and suffering, are not included.

These findings indicate that cigarette smoking contributes substantially to health care costs for the Wisconsin Medicaid program, and raise important issues for public health practice. Clearly, there is a need to improve the delivery of clinical preventive services for smokers, including for low-income groups, such as persons on Medicaid. As more recipients are enrolled in managed care, they can gain access to HMO smoking cessation programs. In Wisconsin, Medicaid includes coverage for nicotine patch and gum therapy, with a prior authorization requirement to show that the client is receiving educational counseling to quit. Medicaid also reimburses for individual and group counseling in alcohol and drug treatment clinics for patients with a nicotine dependence diagnosis. The prenatal care coordination benefit includes coverage for health education to stop or reduce smoking.

An important method of providing prevention education is for all physicians to address the effects of cigarette smoking with patients who smoke. Research has shown that fewer than 60% of smokers report that they have *ever* been advised by their physicians to quit.[6] Yet such physician interventions have proven to be one of the most effective steps toward getting smokers to quit. By recognizing tobacco use as a chronic disease, and recording it as a vital sign of health, the benefits would be twofold: for purposes of data collection to update smoking prevalence, and for incorporation of a change in the delivery of smoking cessation treatment.[7]

In addition to promoting smoking cessation in the clinical setting, there needs to be greater emphasis on prevention of tobacco use as a primary force in public health policy, by promoting clean-indoor-air policies and reducing both youth access to tobacco and tobacco promotion. This is the focus of the Wisconsin Division of Health's ASSIST tobacco control project and the many tobacco-free coalitions in operation throughout the state. Reducing the prevalence of smoking will not only lead to health care cost savings, but also to an improvement in the quality of life of Wisconsin's citizens.

Acknowledgments

The Medicaid cost data was obtained with assistance from: Carla Dew and Mike Boushon in the Operations Monitoring Unit; Peggy Bartels, deputy director, and Kevin Piper, director, of the Bureau of Health Care Financing. Jim Vavra, director of the Office of Management and Policy provided helpful comments. Tom Van Gilder, MD, and Dennis Linn provided technical assistance.

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Public health

Are clinicians intervening with their patients who smoke? A "real-world" assessment of 45 clinics in the upper Midwest

Scott C. Woller; Stevens S. Smith, PhD; Thomas M. Piasecki, MS; Douglas E. Jorenby, PhD; Clay P. Helberg, MS; Richard R. Love, MD; and Michael C. Fiore, MD, Madison

Objective: To determine the level of intervention provided by primary care physicians to individuals who smoke. Setting: 45 primary care clinics throughout the upper Midwest. Patients: 6,086 men and women (M:F = 1:2), ages 50 to 68, who sought medical care at any one of the 45 primary care clinics and completed two questionnaires regarding preventive medical services received during the previous 3 years (1990-1993). Results: Of patients who smoke, 92% reported that their clinician had asked about their smoking status. Additionally, 86% reported being informed at their clinic of the dangers of tobacco use. A smaller percentage of individuals (60.1%) reported being explicitly advised on how to quit, and fewer still (27.2%) reported being referred to a stop smoking program. Conclusions: While most clinicians inquire about their patients' smoking status and recommend they quit, there currently exists a deficiency in the translation of these recommendations into concise, explicit instructions on how to quit. By increasing the frequency of clinicians giving specific advice about how to quit, the overall success rate of the public health campaign against tobacco use will be greatly enhanced. *Wis Med J.1995;94(5):266-272.*

THE SUCCESS RATE of the ongoing public health campaign against tobacco use hinges in part on health care providers seizing their unique opportunity to intervene with patients who smoke. In Wisconsin, more than 70% of smokers express a desire to quit and have attempted to do so at least once.[1] Moreover, smokers routinely cite physician advice as an important motivator in their decision to make a quit attempt.[2] Finally, more than 70% of all smokers see their physician at least once a year making clinicians uniquely poised to aid this captive audience.[3]

Unfortunately, many smokers report that their physicians have neither advised them to quit nor provided them with specific assistance for quitting successfully.[2] Sixty-three percent of current smokers visiting health care settings report not having received any advice to quit from their clinician during the previous 12 months.[2] This low rate of intervention is particularly unfortunate since physician intervention has been shown to increase cessation success rates two- to six-fold.[4] These data, coupled with the fact that patients value their physician's advice, suggest that clinicians are missing a significant opportunity to improve the health of their patients who smoke.

One innovative approach, in addition to training clinicians to intervene with their patients who smoke, is to change the organizational structure of clinics to promote intervention. In a recent study designed to assess the effects of a simple institutional change to promote cessation intervention, researchers at the University of Wisconsin expanded routine vital sign collection to include smoking status.[5] Progress note paper was printed with a vital sign stamp that included smoking status, and this information was documented by a medical assistant prior to the patient seeing a clinician. This minor change in clinic protocol was designed to facilitate the identification of smokers and ultimately increase clinician intervention with patients who smoke. This simple measure resulted in a doubling (from 26% to 53%) in the rate of smokers reporting they were advised to quit. These findings suggest that such institutional changes may be key steps in reversing the low rates of smoking cessation intervention in clinical practice.

Current data on rates of clinical intervention with patients who use tobacco are essential before implementing institutional changes in clinic systems. This is particularly important as more health care in America is delivered in a managed care environment where protocols involving large numbers of patients and clinicians are more common. To provide these data, we evaluated the

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The public health column is coordinated by Patrick L. Remington, MD, MPH, chief medical officer in the Section of Chronic Disease and Health Promotin, Bureau of Public Health; the column is not reviewed by the *WMJ* editorial board. Scott C. Woller is with the Ctr for Tobacco Research & Intervention, UW-Madison; Stevens S. Smith, PhD, and Thomas M. Piasecki, MS, are with the Ctr for Tobacco Research & Intervention and Dept of Psychology at the UW-Madison; Douglas E. Jorenby, PhD and Michael C. Fiore, MD are also with the Ctr for Tobacco Research & Intervention and Div of General Internal Medicine, Dept of Medicine at the UW Medical School; Clay P. Helberg, MS, is with the Dept of Human Oncology, UW Medical School and Richard R. Love, MD is with the Div of Medical Oncology, Dept of Medicine, UW Medical School. Supported in part by grant PBR 51 a-c from the American Cancer Society. Reprint requests to: Michael C. Fiore, MD, MPH, Director, Center for Tobacco Research and Intervention, UW Medical School, 7278 MSC, 1300 University Ave, Madison, WI 53706. Copyright 1995 by the State Medical Society of Wisconsin.

practices of clinicians and reports of patients from a study of 45 clinics throughout the upper Midwest. These data offered a unique perspective on current, "real world" clinical interventions with patients who smoke.

Methods

Project overview. The Primary Care Prevention Project (PCPP) is a multi-year study to assess and improve the provision of cancer prevention services to adults, ages 50 to 68. The study populations are from 45 primary care group practices in the upper Midwest. Data were collected using patient questionnaires, medical record audits, physician questionnaires, and a structural audit. The goals of the study are to: describe current preventive services provided by physicians to patients; identify correlates of the provision of these services; and to investigate two process interventions designed to increase efficiency of delivery of physician preventive services. The current report is based on baseline patient questionnaire data obtained prior to the study interventions. In addition to assessing tobacco use, the PCPP addressed other cancer counseling and screening interventions such as diet, breast self-examination, clinical breast examination, mammography, digital rectal examinations, stool occult testing, sigmoidoscopy, cholesterol testing, Papanicolaou testing, and pelvic examinations.

Subjects and procedures. To describe current clinical practices related to tobacco use, we examined responses from 6,132 patients who obtained their usual medical care at one of 45 PCPP primary care clinics from 1990 to 1993. Each of these clinics was staffed by 3 to 10 physicians who had practiced at a given location for a minimum of 3 years. The study population was restricted to patients aged 50 to 68 that were determined to be regular patients; namely, those having made at least two visits to a clinic during the past 5 years, with one of these visits occurring in the past 2 years. Thus, the study assessed a population which is usually targeted for cancer screening procedures.

Table 1.--Demographic characteristics (n=6086).

	Nonsmoker	Smoker	Overall
Overall population	84% (5102)	16% (984)	100% (6086)
Sex			
Male	85% (1860)	15% (339)	100% (2199)
Female	83% (3242)	17% (645)	100% (3887)
Age			
50–54	81% (916)	19% (209)	18% (1125)
55–59	83% (2248)	17% (461)	45% (2709)
60–65	86% (1938)	14% (314)	37% (2252)
Asked about smoking *status in previous 3 years*	72% (3665)	92% (905)	75% (4570)
Median number of visits to the clinic during *previous 3 years*	7	7	7

A stratified random sampling procedure was used to select patients representative of each physician's caseload and to provide an estimate of the preventive care implemented by the practice rather than that furnished by the individual physician. A 1:2 male-to-female ratio of participants was employed to provide a larger female population for female-specific cancer screening procedures.

Potential subjects totalling 12,525 were selected from patient records of participating clinics using the above specified inclusion criteria. Each potential subject was mailed a short patient questionnaire (SPQ) to determine eligibility and to obtain informed consent under a procedure approved by the University of Wisconsin Committee for the Protection of Human Subjects, and other ethical review boards as applicable for particular clinics. Approximately 2 weeks after mailing the SPQ, a reminder card was sent to the non-respondents followed by a second questionnaire 2 weeks later. Of those initially selected, 6,889 patients (55%) returned the SPQ. Five weeks after this mailing, consenting participants were sent a long patient questionnaire (LPQ) designed to assess theoretically relevant constructs relating to cancer prevention. The 6,132 participants who completed and returned the LPQ served as our database. This represents 89% of the patients that initially completed the SPQ and 49% of the initially identified patient population.

The LPQ asked participants whether they were current or former smokers, and whether their smoking status had been inquired about during any of their clinic visits during the last 3 years. If they affirmed that they currently smoked, they were questioned concerning how long they had smoked and how many cigarettes per day. Additionally, they were asked if anyone in the clinic over the past 3 years had spoken to them about the dangers of smoking. They were then asked to rate from 1 to 4 (1= strongly agree, 4= strongly disagree) the following four questions that were designed to determine, in their opinion, their physician's interest in helping them quit smoking:

- my doctor tries to get me to stop smoking;
- my doctor seems to believe that it is important for me to stop

smoking;

- my doctor is willing to give me advice about convincing me to stop smoking; and
- my doctor seems interested in helping me to stop smoking.

Means, standard deviations, and proportions were computed for the overall sample and for the various subgroupings of patients (eg, men and women). For selected comparisons involving proportions, two-sided χ^2 tests of independence were computed to test for differences between subgroups of interest. For selected comparisons involving continuous-level variables (eg, number of cigarettes smoked per day), two-sided t-tests were computed to test for differences between groups.

Results

Among the 6,132 eligible patients who completed a long patient questionnaire, and had solicited medical care at one of the 45 PCPP facilities during the previous 2 years, 6,086 reported their smoking status and served as the basis for all further analyses. These 6,086 patients included 3,887 (64%) women and 2,199 (36%) men. Some of the sociodemographic characteristics of the assessed population are shown in Table 1. Among these 6,086 patients, 984 or 16% (17% among women, 15% among men) reported that they were current smokers. This rate of smoking is lower than that reported in the 1993 National Health Interview survey, a representative assessment of 20,860 adult Americans, which found an overall smoking rate of 26% among adults aged 45 to 64 years old (23% among women, 29% among men).[6]

Overall, 75% of all patients reported that they had been asked about their smoking status by anyone in the clinic during any visit over the last 3 years, with a slightly higher rate among men than among women (78% and 74%, respectively; ^{2}= 11.1, p<.001). Patients who were current smokers reported they were asked about tobacco use at a higher rate than did non-smokers (92% and 72%, respectively; ^{2}=172.1, p<.001).

Male smokers reported a mean of 22 cigarettes consumed daily and female smokers reported a mean of 18 [t(966)=17.6, p<.001]. Among American smokers in 1991, the mean number of cigarettes smoked was 22 per day for men and 18 per day for women.[7] Our sample also reported a long history of smoking. Overall, the men had been smoking cigarettes for an average of 38 years, while the women had been smoking for an average of 34 years at the time of the survey [t(968)=20.1, p<.001]. The smoking history of this population is summarized in Table 2.

Table 3 summarizes the rates at which smokers reported that their tobacco use was assessed and addressed during their clinic visits. Of smokers who responded, 86% (83% of men and 88% of women, ^{2}= 4.7, p<0.05) reported having been told about the health risks of smoking by someone in their clinic over the past 3 years. When smokers were asked if anyone in the clinic had advised them to quit smoking over the past 3 years, 83% of men and 85% of women responded affirmatively. When asked if anyone in the clinic had talked to them about how to stop smoking, men and women responded affirmatively at a similar rate (58% vs. 61%, respectively, ^{2}=.945, ns). Finally, when asked if anyone in the clinic had referred the smoker to a stop-smoking program over the past 3 years, a similar percentage of men and women responded affirmatively (25% and 28%, respectively, ^{2}=1.5, ns).

To determine if the clinicians

Table 2.--Cigarette use by smokers (n=984).

	Cigarettes smoked/day				Years smoking			
	1–10	11–20	21+	Mean #/ smoker	1–20	21–39	40–58	Mean # yrs smoking
Overall population	25% (241)	47% (452)	28% (273)	19	9% (83)	45% (439)	46% (448)	36
Sex								
Male	18% (61)	43% (144)	38% (128)	22	4% (13)	37% (124)	59% (200)	38
Female	28% (180)	49% (308)	23% (145)	18	11% (70)	50% (315)	39% (248)	34
Age								
50–54	27% (55)	36% (75)	37% (77)	21	10% (21)	77% (158)	13% (26)	32
55–59	25% (112)	49% (222)	26% (118)	19	10% (44)	46% (207)	45% (203)	35
60–65	24% (73)	51% (157)	25% (78)	19	6% (18)	24% (74)	70% (219)	39

were adequately conveying the importance of stopping smoking, patients rated their agreement with four statements about intervention. These data are presented in Table 4. In response to the question "Do you believe your doctor tries to get you to stop smoking?" 78% of men and 79% of women responded affirmatively ("Strongly Agree or Agree"). In response to the question "Do you believe that your doctor thinks it important for you to stop smoking?" more than 87% of both sexes responded affirmatively. In response to the statement "My doctor is willing to give advice about convincing me to stop smoking" 80% of men and 78% of women responded affirmatively. Finally, in response to the statement "My doctor seems interested in helping me to stop smoking" 75% of men and 74% of women responded affirmatively.

Lastly, we assessed the rate at which this older population of patients visited their clinics. Over the previous 3 years, the median number of visits made by both men and women and smokers and nonsmokers was seven (about two visits per year) for all groupings.

Discussion

This study of "real world" clinics in the upper Midwest gives us a current perspective on rates of clinical assessment and intervention with older patients who smoke. While more than 90% of smokers reported that someone at their clinic had asked them whether they smoked, and 84% report having been told to quit, only 60% were advised on how to go about doing so, and fewer than 30% report being referred to a stop smoking program.

These results raise a number of questions regarding the clinician's role in smoking cessation interventions. First, do clinicians ask their patients if they smoke? Our results show that most patients' smoking status is being assessed by their clinicians. More than 75% of all patients--including an encouraging 92% of smokers--report being asked this question. These findings are substantially higher than a recent US population-based report that reported 37% of all patients who had visited a clinic in the past 12 months as being asked about their smoking status.[2] While the higher identification rate in this study may reflect progress by clinicians over time in addressing this issue, other factors may contribute. For example, among this older population, the health complications resulting from chronic smoking may have already become clinically apparent, prompting a higher rate of clinician inquiry about smoking status. This result also may suggest a hopeful development--public health efforts over the last decade to increase rates of clinician assessment and intervention with smokers are working. Finally, recall bias[8] may account in part for the extremely high rates that participants in this survey reported being asked about their smoking status. Recall bias may result from two factors--the long (3-year) period during which individuals were asked to recall clinician inquiries, and the belief that their personal clinicians would be remiss had they not addressed this issue.

Second, do physicians assist their patients in stopping smoking? While 86% of smokers report being advised of the health risks of smoking and 84% being advised to quit, only 60% report being counseled about how to go about doing so.

Table 3.--Rates of clinician intervention with patients who smoke (n=984).

In the past 3 years, has anyone at your clinic:	...told you about the health risks of smoking?		...advised you to quit smoking?		...talked to you about how to stop smoking?		...referred you to a stop-smoking program?	
	Yes	*No*	*Yes*	*No*	*Yes*	*No*	*Yes*	*No*
Overall population	86%	14%	84%	16%	60%	40%	27%	73%
	(839)	(136)	(825)	(153)	(587)	(390)	(264)	(708)
Sex								
Male	83%	17%	83%	17%	58%	42%	25%	75%
	(278)	(58)	(281)	(56)	(196)	(142)	(83)	(252)
Female	88%	12%	85%	15%	61%	39%	28%	72%
	(561)	(78)	(544)	(97)	(391)	(248)	(181)	(456)
Age								
50–54	86%	14%	86%	14%	63%	37%	33%	67%
	(179)	(29)	(180)	(29)	(131)	(77)	(68)	(140)
55–59	87%	13%	85%	15%	61%	39%	28%	72%
	(396)	(61)	(392)	(67)	(281)	(177)	(127)	(329)
60–65	85%	15%	82%	18%	56%	44%	22%	78%
	(264)	(46)	(253)	(57)	(175)	(136)	(69)	(239)

Finally, only 27% report ever being referred to a stop smoking program. These findings are encouraging compared to previous studies. Frank,[9] in a California study, reported 50% of patients as having been told to quit compared to 37% reported in a 1993 national report[2] and 44% by Anda et al[10] in Michigan.

Although the higher percentage of smokers advised to quit observed in this study is encouraging, this percentage may also be partially attributed to cessation interventions prompted by medical complications resulting from life-long smoking in these older Americans. If this is the case, clinician training must focus on inspiring interventions with smokers before the advanced complications of tobacco use are clinically apparent. The use of institutionalized prompts that identify a smoker prior to clinical evidence of a tobacco-related illness might serve this purpose. Additionally, it is also possible that regional factors may be responsible for the higher rates of assessment and intervention. The population sampled in our study is geographically stable and predominantly rural when compared with more transient urban populations. These demographic characteristics encourage long-term patient-physician relationships and may promote a higher level of intervention than in other settings.

Third, are clinicians providing patients with specific advice and assistance on how to quit? While a very high percentage of smokers reported that their clinician had inquired regarding their smoking status and more than 80% reported they were urged to quit, a significantly smaller percentage (60%) reported that they were offered specific advice on how to do so. This finding highlights an important shortcoming in current smoking cessation intervention practice--providing patients with the necessary resources to overcome this powerful addiction. This finding is also consistent with other surveys of physicians indicating that they feel ill prepared to assist their patients who smoke.[11] To assist clinicians, the National Cancer Institute has adopted a brief but effective intervention strategy for clinicians, *How to Help Your Patients Stop Smoking.* [12] This simple intervention plan, designed to be completed in about 3 minutes, urges clinicians to address the 4As with every patient: Ask about smoking at every visit, Advise all smokers in a clear and unequivocal manner to quit, Assist smokers in quitting by setting a stop date, provid-

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Table 4.--Physician interest in smoking cessation as reported by patients (n=984).

My doctor:	...tries to get me to stop smoking.		...seems to believe that it is important for me to stop smoking.		...is willing to give advice about convincing me to stop smoking.		...seems interested in helping me to stop smoking.	
	Yes	*No*	*Yes*	*No*	*Yes*	*No*	*Yes*	*No*
Overall population	78% (758)	22% (208)	87% (841)	13% (124)	79% (753)	21% (264)	74% (713)	26% (251)
Sex								
Male	78% (260)	22% (75)	87% (291)	13% (42)	80% (264)	20% (68)	75% (252)	25% (85)
Female	79% (498)	21% (133)	87% (550)	13% (82)	78% (489)	22% (136)	74% (461)	26% (166)
Age								
50–54	78% (159)	22% (46)	88% (181)	12% (25)	78% (160)	22% (44)	77% (157)	23% (47)
55–59	80% (359)	20% (92)	88% (398)	12% (54)	81% (364)	19% (84)	76% (340)	24% (108)
60–65	77% (240)	23% (70)	85% (262)	15% (45)	75% (229)	25% (76)	70% (216)	30% (91)

ing self help materials, and prescribing nicotine replacement therapy when appropriate, and Arrange at least one follow-up visit within 2 weeks of the quit date. The manual is available free of charge from the NCI (1-800-4CANCER), and has been demonstrated to significantly improve quit rates in primary care clinics.[11]

Fourth, do patients believe their physician is interested in helping them stop smoking? This question was designed to address the effect of the physician's provision of cessation advice as viewed through the eyes of the smoker. More than 75% of smokers in our sample feel their clinician is interested in helping them stop smoking and almost 90% recognize the emphasis their clinician places on their quitting. Four out of five smokers view their clinician as willing to advise them to stop smoking and more than 78% feel their clinician tries to get them to stop. These data are valuable for two reasons. First, they illustrate that patients who smoke are recognizing their physicians as cessation advocates, an important finding since the advice of a clinician is a powerful motivator for quitting.[2] Second, these results can be used as a barometer to measure the effectiveness of clinician intervention as viewed through the eyes of the smoker. In this manner, it is possible to obtain an estimate of the effectiveness of clinician intervention, as reported by the smoking population that is being helped.

One notable finding is that only 27% of smokers reported that their clinician had referred them to attend a stop smoking program. This is of interest because formal cessation programs tend to produce higher success rates than do minimal programs.[13] While this percentage might on first review appear discouragingly low, it may in fact be appropriate when considered in relation to the other findings in this population. These clinicians may be practicing smoking cessation using a stepped-care approach, a model sometimes advocated by tobacco control researchers.[14] This model proposes that all clinicians should provide a minimal intervention as a first line therapy with all of their patients who smoke. According to the model, referral to formal smoking cessation clinics would be restricted to patients who desired more intensive interventions or those who were unresponsive to the minimal clinic intervention by the primary clinician. A stepped-care approach to smoking cessation also is consistent with two important findings regarding smoking cessation: first, most successful smokers quit without the aid of a formal smoking cessation program[15] and second, smokers infrequently take advantage of smoking cessation programs even when readily available.[16] Given the higher rates of effectiveness of intensive intervention, one modification of the stepped-care approach outlined above would be to provide all smokers with a minimal intervention during every clinic visit, as well as information regarding more intense and effective treatments for those smokers willing to attend such programs.

Due to the demographics of the population sampled in this study, there are certain limitations that must be taken into consideration while interpreting these results. The population surveyed consisted exclusively of individuals aged 50 to

68 at baseline. Consequently, these data cannot be considered representative of all age groups. Moreover, because this research was conducted in the upper Midwest, few urban clinics were included. As a result, this population was probably more geographically stable than the overall US population. Finally, this population was homogeneous from a racial and ethnic perspective. More than 98% of the total population consisted of whites. For these reasons, it would be inappropriate to generalize these findings to urban and nonwhite populations.

In summary, this study demonstrates both progress and challenges in confronting tobacco use in primary care clinics. The progress is highlighted by our findings of very high rates of clinicians assessing and advising smokers to quit. An important challenge remains to educate and motivate clinicians to provide specific assistance to smokers in overcoming tobacco addiction. Given their unique access to patients who smoke, clinics and clinicians need to take this key additional step so as to maximize the likelihood that their patients will overcome tobacco use--the chief avoidable risk to their current and future health.[17]

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PCF Board of Governors approves fee reduction

The Board of Governors for the Patients Compensation Fund voted unanimously May 17 to reduce current PCF fee rates by 11.2 percent overall as a direct result of the enactment of the law placing a $350,000 cap on non-economic damages in professional mediacl liability actions. Because of a change in the risk relativity of Fund Class 3 physicians, the actual rate reductions will be 7.2% for classes one, two and four and 20.2% for Class 3 physicians. The current PCF rates for classes one through four are: $3,150; $6,300; $15,750; and $18, 900. The reduced rates effective July 1 will be: $2,923; $5,846; $12,569; and $17,538.

The rate is, of course, subject to legislative change. It is unlikely, however, that the July 1 fund fees will be amended in any way. ❖

Medical society joins health agencies in call for 50-cent cigarette tax hike

THE SMS JOINED Republican legislators and representatives of the heart, lung and cancer associations in a press conference at the Capitol Wednesday, May 17, urging passage of a 50-cent hike in the state's cigarette tax. Sen. Peggy Rosenzweig, R-Wauwatosa, said the 50-cent boost would yield about $157 million a year in taxes and help the state pay for a $1.2 billion property tax relief plan in the 1995-97 state budget.

SMS Past President Richard G. Roberts, M.D., J.D., cited a state Division of Health study estimating that a 50-cent tax increase means 24,000 of Wisconsin's children under 18 would quit smoking. It would also help 50,000 adults to successfully quit, Roberts said. If lawmakers approve the tax--taking Wisconsin's rate to 88 cents and making it the highest in the nation--it is not yet known whether the governor would veto the hike.

The SMS had earlier in the month made an editorial board visit to the *Wisconsin State Journal*, seeking editorial support for the excise tax bid.❖

County society news

Grant. The Grant County Medical Society approved membership for Maria G. P Ilao-Pahm, MD.

Green Lake-Waushara. The Green Lake-Waushara County Medical Society approved membership for Fred Flickinger, MD.

Kenosha. James B. Shack, MD, and Jeanette Richard, MD, have been approved for membership in the Kenosha County Medical Society.

Marathon. The Marathon County Medical Society approved membership for the following physicians: Matthew J. Johnson, MD; Roy A. Brandell, MD; Mark W. DeClute, MD; Eric R. Penniman, MD; and Leo Young, MD.

Milwaukee. The Medical Society of Milwaukee County approved membership for the following physicians: John Kanyi Amuzu, MD; Richard J. Berens, MD; James C. Brandes, MD; Roderick Scott Broadhead, MD; Jerry S. Cohen, MD; Thomas Byrne Conner, Jr, MD; Raymond T. Fedderly, MD; Kevin M. Fickenscher, MD; Claire Fritsche, MD; Peter C. Frommelt, MD; Robert T. Gordon, MD; Arun K. Gosain, MD; Thomas M. Kelly, MD; John H. Kraegel, MD; Andrew M. McDonagh, MD; Dennis J. Maiman, MD; Sootong Park, MD; Sarbjeet S. Sandhu, MD; Suhas K. Shelgikar, MD; Mary Beth Sinclair, MD; Raed Sweidan, MD; Richard James Wakefield, MD; John D. Watson, MD; Rachael L. Weiderhold, DO; Robert J. Wetzler, MD; Joselito Alvarez Baylon, MD; Selim R. Benbadis, MD; Arun Bhandari, MD; Hasan Bit-Shawish, MD; Kenneth James Buley, MD; Victoria Mabutas Cabanela, MD; Gonzalo Duran Castillo, MD; Philip Chih-Hsiao Chiang, MD; Kenneth D. Dembny II,

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Outagamie. The Outagamie County Medical Society approved membership for the following physicians: Peter H. Ackell, MD; David A. Buchanan, MD; Brian T. Eller, MD; William O. Fletcher, MD; D. James Mariano, III, MD; Douglas W. Mielke, MD; Lowell F. Peterson, MD; James E. Quillen, MD; Thomas G. Mattio, MD; Thomas M. Wascher, MD; and Robert L. Wilson, MD.

Vernon. The Vernon County Medical Society met in Coon Valley at the DiSciascio's Coon Creek Inn, on April 3, 1995. The speaker was Gary Semanski from the Black River Falls Memorial Hospital.

Waukesha. The Waukesha County Medical Society approved membership for Patrick G. Krismer, MD.

Waupaca. The Waupaca County Medical Society approved membership for Patti A. Kile, MD; and Richard P. Reigel, MD.

Winnebago. The Winnebago County Medical Society met on April 6, 1995, at the Robbins Restaurant. New members elected into the society include Paul Garcia, MD; and Sandra Roth, MD.❖

Physician briefs

Luz Balmadrid, MD, has opened a family practice at the Primary Care Clinic in Oconto Falls. She studied for her medical degree at the University of Santo Tomas in the Philippines. She completed a residency on anesthesia in Germany and practiced there for five years. She also practiced in New York and most recently at the Wausau Family Practice Center.

Sartaj Dhillon, MD, a doctor of internal medicine, has joined the Milton Clinic. She received her medical degree at Government Medical College, India, and completed her residency in internal medicine at the University of Wisconsin Hospitals and Clinics, Madison.

Clayton Ham, MD,* recently joined the staff at St Joseph's Hospital and Family Practice Clinic of Arcadia. Dr Ham attended college at the University of Saskatchewan-Saskatoon and conducted post-graduate training at Riverside, California. His first general practice was in Richmond, a suburb of Vancouver.

Robert R. Jacobs, MD, of Thiensville, has been elected president of the American Academy of Podiatric Practice Management. Dr Jacobs built and operates the Village Foot Clinic in Thiensville. He graduated from the Illinois College of Podiatric Medicine, and served in the US Army Medical Service at Fort Bliss, Texas and at a MASH unit in Korea. He is former chief of podiatry clinics with the Veterans Administration Center at Wood, Wis.

Richard G. Kardell, DO, has joined the Marshfield Clinic-Chippewa Center. He earned his medical degree from the University of Medicine and Dentistry of New Jersey, School of Osteopathic Medicine in Stratford, NJ. He served his residency in otorhinolaryngology/oro-facial plastic surgery at the University of Medicine and Dentistry of New Jersey, School of Osteopathic Medicine and Kennedy Memorial Hospital, University Medical Center in Stratford, NJ.

Charles LaRoque, MD,* family practice physician, recently joined the staff of Mercy Health System. Dr LaRoque will serve at the Beloit Medical Center. Prior to joining Mercy Health System, Dr LaRoque served as staff anesthesiologist at Beloit Memorial Hospital, St. Mary's Hospital in Green Bay, and Memorial Hospital in Manitowoc. He also served as staff physician in the immediate care center at St Luke's Hospital in Milwaukee. He earned his medical degree from the Medical College of Wisconsin, where he also completed residency training in anesthesiology and family practice. He served an internship at Saginaw Cooperative Hospitals in Michigan.

Richard E. Radak, MD, has joined the Mercy Health System. An emergency medicine physician, Dr Radak will begin as medical director of prehospital services in July, 1995. He has a BS degree in nursing from Northwestern University, Chicago, and an MS degree in anesthesiology from Rush University, Chicago. He served as a frontline EMT and paramedic at the Franklin Park Fire Department Paramedic Services of Illinois. He received his medical degree from the Rush College of Medicine, Chicago, and completed an internship and residency in emergency medicine at Cook County Hospital, Chicago.

Steve A. Weber, DO,* joined the Wild Rose Clinic in February. He has more than eight years of experience in family practice and is board eligible in emergency medicine. He graduated from the Chicago College of Osteopathic Medicine and completed an internship and family medicine residency at Brentwood Hospital in Cleveland. ❖

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Pamela Wilson, MD
Dr Harry & Kathleen Zemel

In Memoriam
In loving memory of those individuals who will grace our paths forever.

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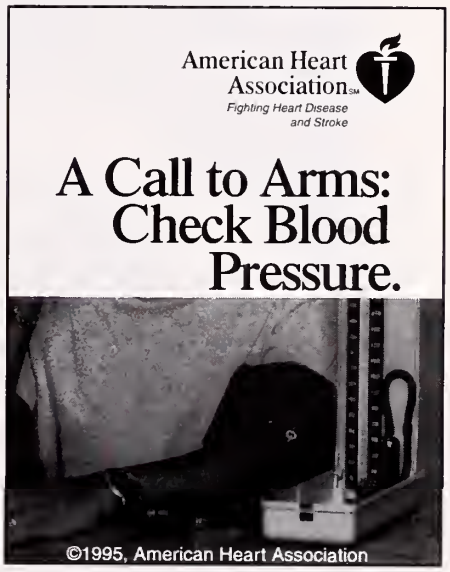

AMA awards

The Wisconsin physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates members of the SMS.

February

Abujamra, Fawzi N.
* Butler, Pamela J.
* Christenson, Brian C.
* Garner, Harold B.
* Hanson, Allen S.
* Johnson, Steven R.
* King, Christopher
Kraegel, John H.
* Kurtz, Jeffrey A.
* Lee, Jong M.
* Lieberthal, Alan S.
Liedtke, Arthur J.
* Marquis, Stephen J.
* Martin, Carroll M.
* Mc Wey, Patrick J.
* Mukherjee, Rama P.
O'Loughlin, Peter D.
* Pasic, Thomas R.
* Paulson, John K.
* Reiser, Gregory
Rupley, David C.
* Schroeder, Norman J.
* Wong, Walter

March

* Agens, John E.
* Best, Catherine M.
Drury, Colin J.
* Flickinger, Roger R.
* Frechette, Paul F.
* Gager, Walter E.
* Garvida, Cesar A.
* Gehring, Charles J.
* Grotenhuis, Paul W.
* Hamacher, John E.
* Hammer, Roland M.
* Huberty, Lee H.
Ilada, Patricio L.
Laabs, John E.
Laughlin, Kathleen M.
* Loewenstein, Paul W.
* McCormick, Michael R.
* McMillen, Milton R.
* Merriman, Kim A.
Meyer, Edward D.
Miller, Scott B.
Mueller, Wade M.
* Newton, Carolyn G.
* Pierce-Ruhland, Richard A.
* Rammer, Martin A.
* Renfrew, Donald L.
* Rietbrock, Michael J.
* Rizzo, Michael J.
Rozario, Nirmala J.
* Sankovitz, Patrick J.
* Seidl, John J.
* Sharma, Divya
Strehlow, Scott R.
* Ullrich, Peter
* Warren, Scott H.
* Weber, Joseph W.
* Woeste, David M.❖

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- Submit papers to: *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701; Ph: 608-257-6781 or 1-800-362-9080; FAX: 608-283-5401.
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Results—Provide results in the test, tables or illustrations. If tables or illustrations are used, emphasize or summarize only the most important observations in the text.

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STOUGHTON, WISCONSIN. Dean Medical Center, a 350 physician multispecialty group, is actively recruiting a BE/BC family physician for our Stoughton Clinic, which is located approximately 20 miles south of Madison (population 190,000). Currently there are 3 internists, 4 family practice physicians, 1 pediatrician and 1 general surgeon at this clinic. Call would be shared equally among the family physicians. The Stoughton Hospital is a 50 bed facility adjoining the new medical office building. Stoughton has a population of approximately 9,000 and growing with excellent schools and neighborhoods. This is an excellent position which enables you to live in a safe community with the cultural and professional resources of a larger city just minutes away. A two year guaranteed salary plus incentive and benefits is being offered for this position. Contact Scott Lindblom, Dean Medical Center, 1808 West Beltline Highway, Madison, Wisconsin, 1-800-279-9966, (608) 250-1550 (work), (608) 833-7985 (home) or FAX (608) 250-1441. 5-7/95

EMERGENCY MEDICINE: Be a partner in your own independent democratic group in a family oriented community located 1 hour northwest of Milwaukee. Low volume Emergency Department. Medical Director and staff positions available (moonlighting opportunities also available). Call 414-332-6228 or send CV to the Emergency Resources Group, 509 W. Montclaire Avenue, Milwaukee, Wisconsin, 53217. 5/95

PEDIATRICIAN - B/C, B/E to join Pediatric Associates in Milwaukee, St. Joseph Hospital-Sherman Park community. Competitive salary, generous fringe benefits. Reply to Malke, c/o Pediatric Associates, 4267 W. Fond du Lac Ave., Milwaukee, WI 53216. 4-6/95

JANESVILLE, WISCONSIN. Dean Medical Center, a 300 physician multispecialty group, is actively recruiting additional BE/BC family physicians to practice at the Riverview Clinic locations in Janesville, Milton and Delavan, Wisconsin. Traditional family practice and urgent care opportunities are available. Janesville, population 55,000, is a beautiful, family oriented community with excellent schools and abundant recreational activities. Excellent compensation and benefits are provided with employment leading to shareholder status. Send CV to Stan Gruhn, MD, Riverview Clinic, PO Box 551, Janesville, WI 53547 or call (608)755-3500. An Equal Opportunity Employer. 4-6/95

MADISON, WISCONSIN. Dean Medical Center, a 300 physician multi-specialty group, is seeking additional family physicians to join its 30 member department. Positions are located at our Arcand Park, East Madison and Deerfield Clinic locations. All positions have an excellent call schedule and obstetrics is optional. Madison is the home of the University of Wisconsin with enrollment of over 40,000 students and the state capital. Abundant cultural and recreational opportunities are available year round. Excellent compensation and benefits are provided with employment leading to shareholder status. For more information contact Scott M. Lindblom, Dean Business Office, 1808 West Beltline Hwy., PO Box 9328, Madison, Wisconsin, 53715-0328, work at 1-800-279-9966, (608) 259-5151 or at home (608) 833-7985. An Equal Opportunity Employer. 4-6/95

JANESVILLE, WISCONSIN - URGENT CARE. Riverview Clinic, a division of Dean Medical Center, is actively recruiting an urgent care physician to join its medical staff. We recently in-

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creased our compensation package which is based on a 40 hour work week. Total compensation for Year 1 - $108,000.00, Year 2 - $134,642.00 and Year 3 - $135,000.00. We currently have two physicians which staff the clinic from 9:00 am - 9:00 p.m. Monday through Friday and 9:00 am - 11:30 am on Saturday and desire to expand the hours of operation until 9:00 pm on Saturday and 1:00 pm - 9:00 pm on Sunday. Our facility is brand new and well equipped with 8 exam rooms, lab and x-ray. Flexible hours are available with an expected total of 30-40 hours per week. Excellent compensation and benefits are provided. For more information contact Scott M. Lindblom, Dean Medical Center, 1808 West Beltline Highway, Madison, WI 53713, (work phone) 1-800-279-9966 or (608) 259-5151, Fax (608) 259-5294, (home phone) (608) 833-7985. 4-6/95

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3-5/95

NORTHERN ILLINOIS - Saint Anthony Medical Center, a 280-bed Level I Trauma Center in Rockford, IL, offers a tremendous opportunity for BC/BE Family Practice Physicians. Growing practice offers at least 1 in 4 call. Strong primary care physician group provides quality patient care and friendly colleagues. Offices are managed by practice management experts. Competitive salary and comprehensive benefits package offered. Saint Anthony is a member of OSF Healthcare. For more information, contact Marie Noeth at 800-438-3745 or fax CV to 309-685-2574. 4-6/95

WISCONSIN. BE/BC FP physician needed in clinic-based Urgent Care Center - part of a 35-physician multi-specialty group in west-central Wisconsin. Practice full time with some evenings and weekend hours; no call. Beautiful city of 60,000 in west central Wisconsin, 90 miles from Minneapolis/St. Paul. Competitive salary and excellent fringe package. Contact James Volk, MD Medical Director, Group Health Cooperative, PO Box 3217, Eau Claire, WI 54702-3217. (800) 218-1745. 4-7/95

LA CROSSE, WISCONSIN. Board certified residency trained emergency medicine or family practice physician needed to join four other emergency physicians at St. Francis Medical Center. 13,000 annual ER visits, 100 active medical staff members. Well-equipped community hospital with 8,000 annual admissions. Member of Franciscan Health System, currently affiliating with Skemp Clinic and Mayo to form integrated regional practice based in La Crosse. La Crosse located in scenic Mississippi River bluff country with excellent fishing, hunting, boating. Ideal family-oriented environment. Good public and private schools. Contact Charles Link, MD, Vice President Medical Affairs, Franciscan Health System, 700 West Avenue South, La Crosse, WI, 54601, 608-795-0940. 4-6/95

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MADISON, WISCONSIN - URGENT CARE. Dean Medical Center, a 300+ physician multispecialty group is seeking a full time physician to assist in staffing our two urgent care centers. Qualified applicants should be BE/BC in Family Practice, Emergency Medicine or Internal Medicine with experience in Pediatrics. Dean Medical Center operates two Urgent Care Centers 365 days per year, from 7:00 a.m. - 10:00 p.m. All physicians employed at the urgent care centers are paid on an hourly basis, and full time physicians are eligible to go on a shareholder track and buy into the corporation after two years of employment. Excellent compensation and benefits with shareholder eligibility after two years of employment. For more information contact Scott M. Lindblom, Dean Medical Center, 1808 W. Beltline Highway, P.O. Box 9328, Madison, Wisconsin, 53715-0328, at work 1-800-279-9966 or (608) 259-5151 or home (608) 833-7985. 3-5/95

LANCASTER, WISCONSIN. Dean Medical Center, a 300+ physician, private, multi-specialty group, is actively recruiting for one Board Eligible/Board Certified family physician to practice at the Grant Community Clinic in Lancaster, Wisconsin (population 4,200)

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Physicians Exchange

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BEAVER DAM, WISCONSIN. Medical Associates of Beaver Dam is actively recruiting a BE/BC family physician to join its staff of six family physicians. Call is shared equally and all hospital admissions are at our local 100 bed hospital. Beaver Dam is a safe, family oriented community of 15,000 located 45 minutes north of Madison with excellent schools and four season recreational opportunities. Excellent compensation and benefits are provided. For more information, please contact Scott M. Lindblom, Medical Staff Recruiter, Dean Medical Center, 1808 West Beltline Highway, 1-800-279-9966, (608) 259-5151, FAX (608) 259-5294 or at home (608) 833-7985. 3-5/95

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Medical Meetings - Continuing Medical Education

June 9-10, 1995
Wisconsin's two medical schools, the Medical College of Wisconsin and University of Wisconsin-Madison, will sponsor a CME program entitled "Cancer in Older People - Clinical Challenges and Practical Approaches". The course will be held Friday (all day) and Saturday (am) June 9-10, 1995, at the Grand Geneva Resort and Spa located in scenic Lake Geneva, Wisconsin. This course is designed to provide participants with state-of-the-art knowledge in diagnosis and management of common cancers in relation to the older patient. Enrollment is $100.00 and includes a comprehensive course syllabus, meals, and CME credits (12.0). The Grand Geneva Resort and Spa will offer a very special rate of $89 per night (if received by May 9th) for all participants. The resort hosts two nationally acclaimed 18-hole golf courses, indoor and outdoor swimming pools, complete fitness center and spa facilities, tennis and racquetball courts and horseback riding. Registrations for this course must be received May 26, 1995. If you would like additional information regarding this program, please call Edmund Duthie, MD at (414) 384-2000, X-2775. 4-5/95

ISSUES IN PRIMARY CARE CONFERENCE. Friday, September 15 - Saturday, September 16, 1995. Landmark Resort and Conference Center, Egg Harbor, Wisconsin (Door County). Contact: Marshfield Clinic, Office of Medical Education, 1000 North Oak Avenue, Marshfield, WI 54449. 1-800-541-2895. 5-6/95

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THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, clinics, specialty societies, and medical schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 70 cents per word, with a minimum charge of $30.00 per listing. *All listings must be prepaid.*

BOXED LISTINGS: $40.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 1st of the month preceding the month of publication: eg, copy for the August issue is due by July 1. Address communications to: *Wisconsin Medical Journal*, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free 1-800-362-9080.

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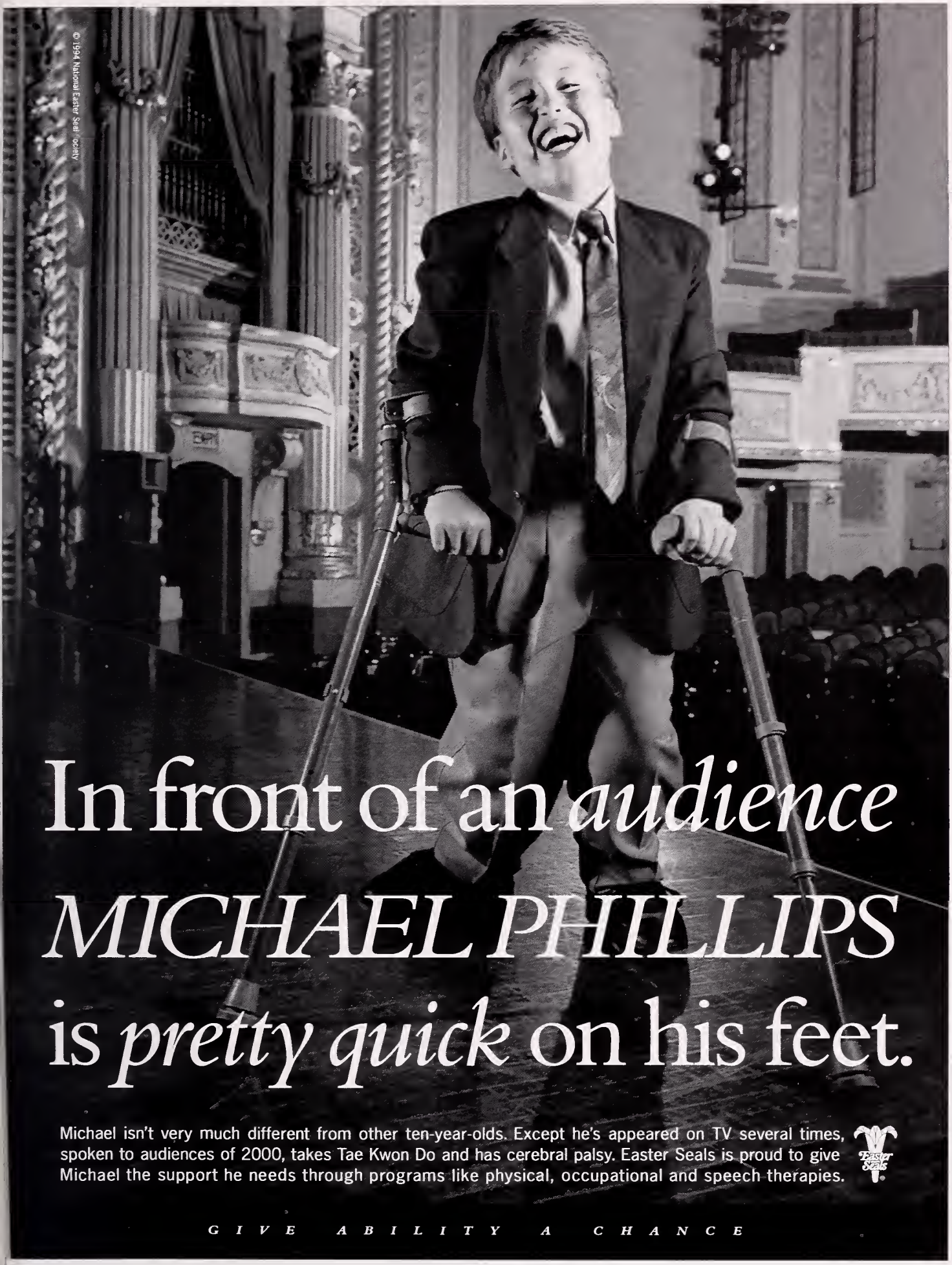
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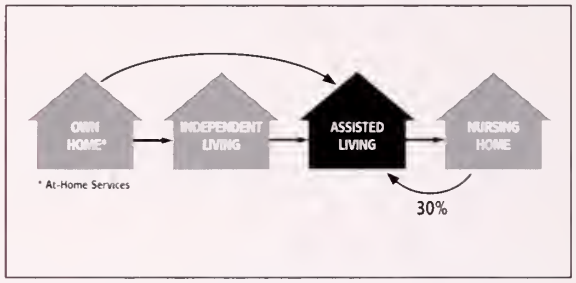

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State Medical Society of Wisconsin

Created by the Territorial Legislature in 1841 and now representing nearly 8,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal*.

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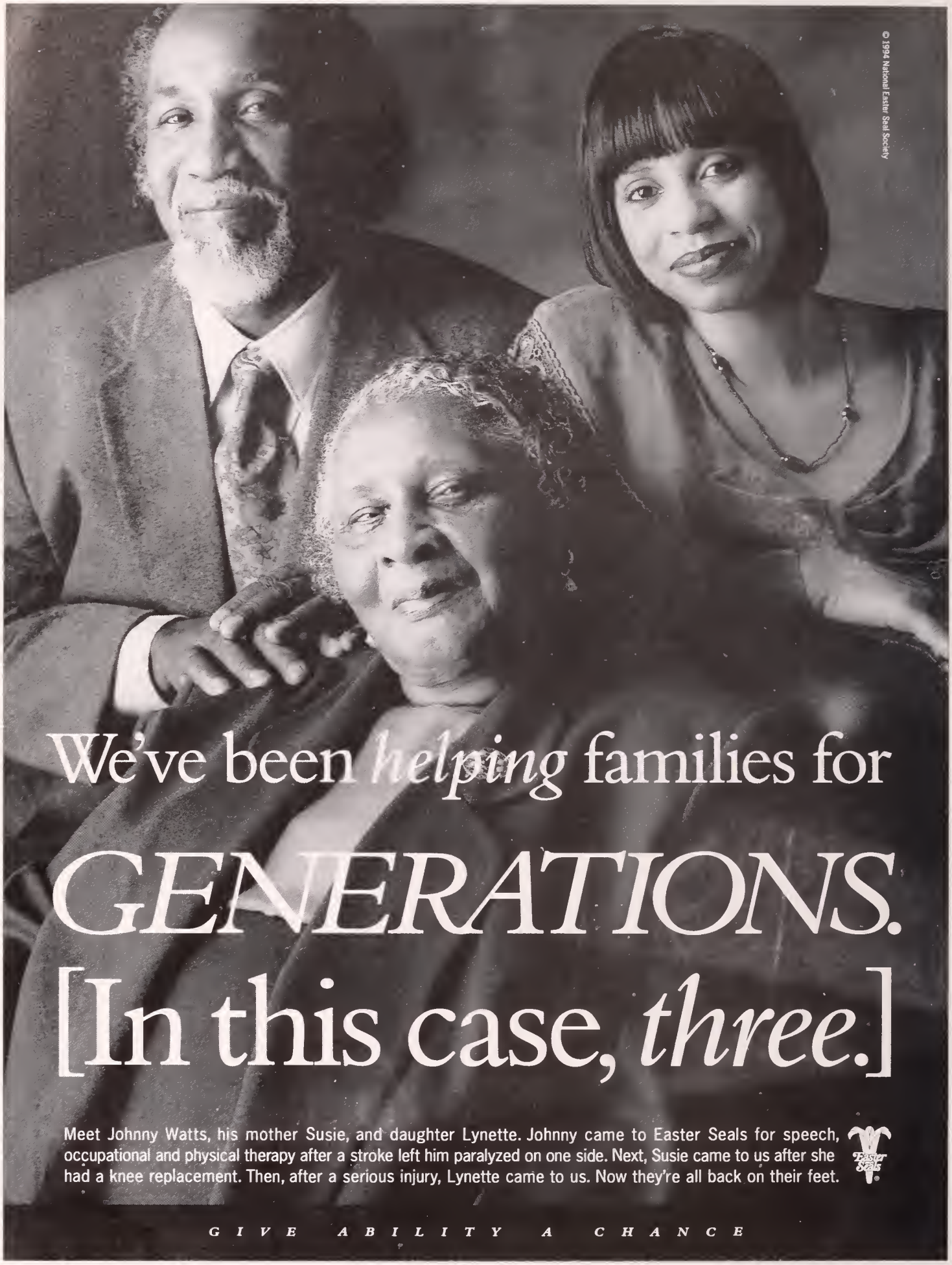
Our cover: An agave plant, native to the southwestern United States, distinctive for its stiff smooth leaves with bristling spines. SMS President Marcia J. S. Richards, MD, finds photography and travel can provide a welcome respite from everyday practice concerns. She has, however, set her camera aside during her busy presidential term. (See page 289.)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GIVE ABILITY A CHANCE

President's page

How did we manage to get to where we are? (and where are we going anyway...)

"What lies behind us and what lies before us are small matters compared to what lies within us."
--Ralph Waldo Emerson

I know for certain that I do not wish to go back to the years I spent in medical school and residency training. Not that they weren't good years, they were. Rather, I think that I am getting too old, (as I come within a few months of the half century mark), to return to the sleepless nights of study, periodic exams, and histories and physicals that take several hours to complete.

Sometimes I also do not want to peer into the future, for I enjoy the present practice of medicine. But then a referral form arrives on my desk and I know that I must, for the future is already here. No longer do I receive new patients only on my merit as a physician, but I receive them because I am a name on a "panel of providers" for a health plan. No longer can I always schedule a surgical procedure or costly diagnostic test without calling for authorization, and no longer can I routinely enter a patient on a research trial when his or her cancer fails to respond to conventional therapy.

Slowly at first, and now with accelerating speed, managed care is altering the way I practice medicine. It is this new environment to which I need to adapt.

Over a decade ago, managed care plans were a special boutique insurance. But now, they are the rule rather than the exception. In Wisconsin 24 percent of the non-Medicare patients are currently insured by managed care products, up 7.3 percent in the last 10 years, and rising. Medicaid patients in Wisconsin were some of the first to be covered in these plans, and the federal government has indicated that they are hoping to enroll many Medicare participants in managed care options to try and deal with the projected Medicare financial problems. Similarly, we now find almost all physicians participating in some managed care products with increasing amounts of a physician's income derived from patients enrolled in their insurance plans.

Up to now, managed care had meant for me having access to patients enrolled in a plan, and excluded from that patient population if I did not participate. Additionally, my fees were discounted off my standard price with few questions asked about the number of charges submitted. But these are simple times compared to the future.

Marcia J. S. Richards, MD

In the future I will be asked to assume risk with capitation products, a scenario where doing less for the patient may mean doing better in my take home pay. And at the same time, I am asked to better support my plan of care, and report on my outcomes if I want to continue on the panel of approved physicians. Sounds like I will be doing more for less.

But will it really be doing less? Or,

Continued on next page

Continued from preceding page
can you and I while learning to provide medical care under a different environment perhaps also do some things better for both our patients and ourselves?

This is our challenge. The road construction cannot be reversed; jackhammers have already broken up familiar pavement and the earthmovers are coming through. There is no rewind or reverse button for our current situation.

I believe that by working together with our medical organizations, other providers of health care, our patients, and by staying involved in the political process which effects our practice of medicine, we can improve health care, both for our patients individually, and for society as a whole. We must gear up to meet this challenge. This next year I will use this page as a window on the future, looking out over the landscape of managed care. I intend to report on areas of current and future areas for potential advocacy.

Together we must work with others on building direct and efficient paths, roads, and highways through this new land of managed care. We must build routes on which we, as doctors with our patients, can safely travel. We must build wider roads to allow greater access to health care services. And, we must work to make the roads of health care delivery straighter and smoother than currently surveyed.

I believe Wisconsin physicians and our patients have the inner strength needed to carry out this task. If we don't, we will have no one but ourselves to blame for the developing potholes or meandering routes set in place by others who labored alone--without physician support or involvement.❖

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EVP report: The view from here
Seeking success in shark-infested waters

"A house divided against itself cannot stand."

--Abraham Lincoln

You, the members of the medical profession, are about to be tested as never before. The new Republican majority in the U.S. Congress has vowed to balance the budget in seven years. Their ability to achieve that goal will necessitate slowing significantly the rate of growth in the Medicare and Medicaid programs.

The push to decrease spending for health programs is neither pretty or to the liking of politicians bent on reelection. This is politics of the highest emotion; politics with the people's face. Key national interest groups ranging from doctors and hospitals to senior citizens, labor unions and business will be pitted against each other in a feeding frenzy--attacking each other and churning the bloodied water time and time again.

In fact, as the debate rages and votes on specific programs occur, the coalitions will swirl and change, shifting allies with the issues. On one day, it may be doctors and seniors against insurers and hospitals; the next debate may team hospitals and seniors against doctors and insurers. There will be no permanent alliances in these debates, but rather a constantly shifting confluence of special interests.

Those descriptions, I hope, will give you pause. It's been said that the worst thing about winning the rat race is finding out in the end that you're still a rat. The same might be said of sharks in a feeding frenzy. When the water calms, you're still a shark.

That's why we must be prudent and exercise caution as this significant debate begins. In the public's eye, the term "doctor" will include all physicians in all specialities as a single unified voice. If doctors consistently fight for what is right for their patients, they won't be seen as sharks in the public's eye. But if one speciality is nipping and gashing at the others or trying to cut deals that would likely provide only short-term relief at the expense of other items in Medicare Part B, the dorsal fins will sprout along with rows of jagged teeth.

To pit speciality against specialty, doctor against doctor, patients against doctors would, as President Lincoln observed, be a blueprint for disaster.

Speaker Gingrich and the Republican leadership have asked the American Medical Association to take a zero-based look at Medicare and make recommendations as to how to reduce expenditures in the program. For the next few months, I hope every physician can support the AMA in its efforts and then go on to support the final work product.

In the interim, the State Medical Society's Executive Committee has asked the AMA to work to accomplish the following goals:

- Shift the debate from provider cuts to reforms in Medicare financing.
- Minimize the level of physician and graduate medical education cuts.
- Pass legislation with patient protections, point of service options, antitrust relief, new opportunities for physician-sponsored networks, liability reform and real regulatory relief.
- Balance financial incentives for competing Medicare plans to assure that freedom of choice is not priced beyond the means of large segments of the Medicare patients.

Thomas L. Adams, CAE

If the profession does not stand together this time, rising above individual and specialty interests, both you and your patients stand to lose. You will lose physician autonomy and they will lose quality health care. It's "big picture" time, folks. We can't be drift into the role of sharks, satisfied with self-serving solutions. We must reach consensus, throw all of our talents into the sea together, and pull home reforms that benefit everyone. ❖

Letters

SMS involvement in Marshfield brief 'most inappropriate'

To the editor: It was appalling that the State Medical Society voted in a most inappropriate fashion to assist the Marshfield Clinic in appealing its Federal Antitrust Court conviction. It is apparent to all of the rural physicians that the board of directors of the Wisconsin State Medical Society consists of a majority of physicians associated directly and indirectly with the Marshfield Clinic. It is inappropriate for those physicians associated with the Marshfield Clinic to actually have voted on the level of the board of directors to support this filing of a supportive legal brief in this particular case.

At no time during the entire discussion has a finding of fact with regards to the accusation which the Marshfield Clinic was found guilty of been published. In essence, one of these is that they have driven members of the State Medical Society of Wisconsin out of practice and out of the state. This is well documented in the court testimony. The State Medical Society by its action has therefore supported the antitrust actions of the Marshfield Clinic against other members of the State Medical Society of Wisconsin.

This is not a circumstance where the Marshfield Clinic comes into an area and gains an advantage in patient care based on the provision of more suitable medical care. It is a circumstance where the Marshfield Clinic has come into an area and, utilizing illegal antitrust activity, attempted to monopolize and control the medical care delivery market in the areas that it has come into.

The Lincoln County Medical Society, which is quite representative of independent physicians practicing medicine in rural Wisconsin, submitted to the State Medical Society a resolution which stated that the State Medical Society should literally stay out of this particular state and let the arguments continue between Blue Cross/Blue Shield and the Marshfield Clinic group.

For the State Medical Society to join the Marshfield Clinic and submit a brief as a friend of the court represents truly that it is a friend of the Marshfield Clinic, but certainly not a friend of the maintenance of independent physician practices in rural Wisconsin. These independent physician practices all represent dues paying physicians belonging to the State Medical Society of Wisconsin.

What the State Medical Society has done is incorrect, and the participation of the American Medical Association in this suit at the request of the State Medical Society is even more incorrect. Antitrust violation of the law has been practiced by the Marshfield Clinic. The argument that they are providing required care where it is not provided otherwise really does not hold much water when they have been extremely effective in driving out of the communities they come into any physician offering them any type of competition utilizing illegal antitrust modalities.

I certainly did not pay my dues to the State Medical Society of Wisconsin or the American Medical Association to have that money utilized to support an illegal antitrust action accomplished by the Marshfield Clinic to drive me and my other independent physicians out of practice in rural Wisconsin.

--J.S. Mayersak, MD
Wausau

Editor's Note: The only member of the SMS board of directors present from the Marshfield district was Board Chair Dr Richard Ulmer. To avoid the appearance of impropriety, Dr Ulmer stepped down and Dr Raymond Zastrow chaired the meeting during the discussion of the Marshfield case. Further, although the board made a recommendation to file the amicus brief, the final decision whether to file the brief was made by the house of delegates.

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

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After several hours of debates in the reference committees and district caucuses, and a long time spent hearing testimony on the house floor, the house voted in favor of filing the brief. As to the nine counts against Marshfield, they are certainly a matter of public record. However, the reference committee recommended, and the house approved, not to publish the nine counts because it was felt to be premature as the appeals process was still pending.

The amicus brief of the State Medical Society does not support the Marshfield Clinic or its actions. The nature of an amicus brief mandates it be filed on behalf of one of the initial parties to the action. Thus, in order for the State Medical Society to respond to this nationally important legal issue, the brief must either be filed for Blue Cross/Blue Shield or Marshfield. That the brief is to be filed on the side of Marshfield Clinic does not mean that the legal arguments presented in it advance Marshfield's legal arguments. The arguments contained in any amicus brief focus more on public policy issues and the ramifications the case's result could have on others. The facts of the particular case at bar become almost secondary. This is especially so here because antitrust violations are fact specific. In this case, it is the ramifications on other physicians, especially in rural areas, who attempt to integrate the market place that the State Medical Society is concerned with.

Finally, the brief will not address the allegations of Marshfield's egregious actions or whether or not Marshfield violated antitrust laws. The brief will be limited to the following five points which the board of directors and the house of delegates authorized.

- The expansion of integrated networks of health care providers and group practices into sparsely populated areas holds the potential to improve access to high quality care, and should not be discouraged.
- The expansion of health care providers into health care financing, such as an HMO, holds the promise of offering consumers more choices than non-provider controlled insurers can offer. A health care financing product should not be disadvantaged simply because it is owned by physicians practicing in a market.
- All physicians, including those in group practices, who have built a reputation for high quality ser-

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Continued from page 293

vices should be allowed to negotiate contracts with payers that compensate the providers for the reasonable value of those services.

- The antitrust laws, which are important in furthering the interests of consumers in choosing among different providers and systems of providers and between different forms of health care financing, can chill the very competition they are designed to encourage when used in an undisciplined manner. An antitrust plaintiff should have to clearly identify how a defendant's particular conduct, in a particular market, resulted in antitrust damages to the plaintiff.
- Antitrust damages must take into account quality of care in the particular circumstances. Crude measures of damages potentially chill investments in quality by providers in sparsely populated areas, where, of necessity, the provider may have a large market share in some physician services market. Consumers in rural areas may welcome, and be willing to pay for, such quality and access.

The brief is being filed to prevent Wisconsin physicians and physicians nationwide from being bullied by the large insurance companies. It is because physicians are on an unequal playing field with insurance companies, insurance companies are specifically exempted from antitrust laws, that this brief will address and support organized medicine's belief that physicians should be allowed to work together to create physician directed integrated networks. In filing this brief, the SMS hopes to "level the playing field." The brief will not condone any physician violation of the antitrust laws or alleged egregious actions.❖

Single payment area

To the editor: Having spent most of my life in rural Wisconsin and seeing the lack of care that unfair reimbursement has caused in many areas, I wish to convey kudos to the physicians of Racine and Dane county, in particular, for their unselfish support of a Medicare single payment locality. At the same time, one wonders about the sense of fairness of the physicians in Milwaukee county, 84% of whom somehow feel they should be reimbursed higher than physicians in rural areas for the same work and training.

It's a shame that HCFA has seen fit to attempt to further geographically divide physicians in the state of Wisconsin so that they themselves don't have to make the difficult choices.

--D. Mark Lochner, MD
Waupaca

Editor's note: The 84% figure should be noted does not refer to all Milwaukee County physicians. The response rate for the survey was 34%.❖

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Soundings
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Into black cellophane pondering
Pictures of critical importance

But

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And the shapes
Of the curious bats
And the skull that grins
Or the poodle heads
I try, I really do
To sweep them away
With my leftbrain broom

But then

These creatures
Their tenacious images
Thrive
Their existence is undeniable
And they become increasingly
Real

--Reuben Lubka, MD
Wauwatosa❖

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Inflammatory pseudotumor of the bladder

John R. Sty, MD; Robert G. Wells, MD; and Robert C. Hardie, MD, Milwaukee

INFLAMMATORY PSEUDOTUMORS are so named because they mimic malignant tumors, clinically and radiologically. Most often, the lesion involves lungs in young adults. There are scattered reports of these tumors occurring in other sites in children. Other organs of involvement include liver, stomach, spleen, small bowel, mesentery, pancreas, kidney, thyroid, spinal cord, meninges, and bladder.[1,2]

Tumors of the bladder in children are extremely rare and more often malignant than benign. Embryonal rhabdomyosarcoma is the most common neoplasm of the lower urinary tract in childhood, usually affecting children under the age of 5. Benign lesions of the bladder include neurofibroma, hemangioma, pheochromocytoma, transitional cell papilloma, leiomyoma, and inflammatory pseudotumor.[3,4]

Inflammatory pseudotumor of the bladder is a rare condition in childhood characterized by the presence of a mass that simulates a true neoplasm. These lesions usually grow slowly and do not metastasize or undergo malignant transformation. Accurate diagnosis before and after excision is the main difficulty of this space-occupying lesion. Although sonography can easily detect the presence of a bladder mass, it is not able to specifically characterize the lesion as inflammatory pseudotumor.

Dr Sty is chief of radiology, Dr Wells is staff radiologist and Dr Hardie is a radiology fellow; all are with the Department of Pediatric Radiology, Children's Hospital of Wisconsin, in Milwaukee. Reprint requests to: John R. Sty, MD, Chief of Radiology, Children's Hospital of Wisconsin, 9000 W Wisconsin Ave, #721, Milwaukee, WI 53226. Copyright 1995 by the State Medical Society of Wisconsin.

Case report

The patient is a 10-year-old male who presented with pelvis pain that was intermittent and a 6-day history of gross hematuria, including passage of clots. He had no previous symptomatology related to the pelvis or abdomen. He had been started on oral antibiotics 3 days prior to admission for a presumed urinary tract infection. Vital signs were normal with the exception of orthostatic hypotension. There was no fever or other symptoms that would indicate infection.

Laboratory evaluation was normal except for a hematocrit of 17 with normal WBC count. The urine analysis demonstrated 4+ packed red blood cells. A sonogram was obtained and showed a large mass in the bladder (Fig 1). The kidneys were normal. Computed tomographic examination with intravenous contrast supported the diagnosis of a bladder mass (Fig 2).

The child was taken to surgery and a biopsy was performed. The diagnosis was difficult to establish on the frozen section, so resection was not attempted. The following day the diagnosis of inflammatory pseudotumor was established. The patient then returned to surgery and a resection of the lesion was accomplished. The child demonstrated an uneventful postoperative course.

Discussion

This rare tumor simulates a true neoplasm, both clinically and morphologically, and because of this, inflammatory pseudotumor (IPT) presents a diagnostic and therapeutic dilemma. The etiology of IPT is not defined. A history of trauma, infection, or previous surgery is sometimes present and the development of these masses is thought to be the result of an over-response of the tissue to a variety of insults of external origin. Some authors attribute IPT to response mechanisms of immunologic processes. Some patients with IPT present with fever, anemia, hypergammaglobulinemia, and thrombocytosis.

In children, the most obvious lesion in the differential diagnosis is embryonal rhabdomyosarcoma; this diagnosis was entertained on our original sonographic evaluation. Both lesions usually appear as a polypoid mass projecting into the lumen of the bladder and less commonly as only bladder wall thicken-

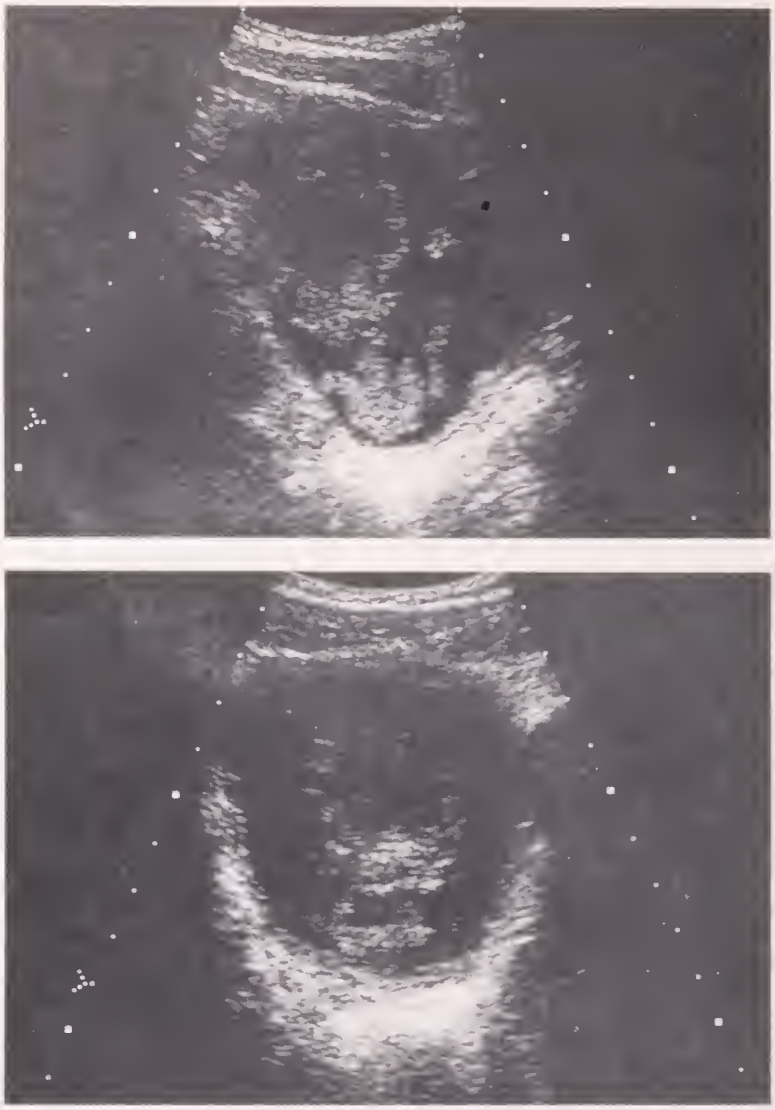

Figure 1A (top) and 1B (bottom).—Longitudinal (A) and transverse (B) ultrasound images of the pelvis reveal a mass within the lumen of the bladder. This mass has heterogeneous echogenicity. Centrally, there is decreased echogenicity. The borders of the mass are irregular. Echogenic clotted blood is visible adjacent to the mass.

ing. The polypoid lesion is frequently complex, with hypoechoic areas representing hemorrhage and necrosis identified with sonographic techniques. Occasionally, the mass is homogeneously echogenic. Hydronephrosis and invasion of perivesical structures can occur with both embryonal rhabdomyosarcoma and IPT. When the tumor causes diffuse thickening of the bladder wall, it is usually associated with cystitis.

At surgery, these tumors are usually large masses with smooth glistening surfaces. The diameter of these lesions range from 5 to 15 cm. They can arise from an organ on a vascular peritoneal pedicle or they may infiltrate the structure of origin to a variable extent. This latter finding usually occurs in the bladder, uterus, and lung. They are also often adherent to surrounding organs, but can be peeled away without injury to, or resection of, those organs. When an incision is made through the lesion, they are frequently a yellowish-tan to gray-white color. Usually they are firm, often with nodular fibrotic changes. On occasion, areas of calcification may be identified.

Histopathologic examination is essential for the differential diagnosis among rhabdomyosarcoma, leiomyoma-leiomyosarcoma, and inflammatory pseudotumor. Microscopic examination of an inflammatory pseudotumor shows a mesenchymal-like stroma in which tapering fibroblasts contain pale, bland nuclei. A fine scarring capillary network with sparse inflammatory infiltrate of plasma cell, lymphocytes, and neutrophils is noted.

In the periphery of the mass, there frequently are foamy histiocytes. In the bladder wall there is usually a heavy inflammatory infiltrate with the formation of lymphoid follicles with germinal centers. A leukocytoclastic vasculitis is also present. Frozen section diagnosis is difficult, as is deciding whether to perform radical excision. The polymorphic histology makes the diagnosis difficult.

If plasma cells are predominant, it often is difficult to distinguish these lesions from plasmocytomas; however, immunohistochemistry demonstrates that they consist of polyclonal rather than monoclonal plasma cells. Differentiation from the more common sarcoma, and even lymphoma, may be difficult as histologic pattern may be story form and the cell predominance may be of the type seen in myosarcomas, myxofibrosarcomas, fibrohistiocytomas, or even lymphoma. Electromicroscopy frequently distinguishes these lesions from malignancy, due to the lack of ultrastructure evidence of neoplasia.

Presently, the optimal treatment for inflammatory pseudotumor is complete excision, which is usually possible with minimal morbidity. The malignant appearance of this tumor could lead to radical surgery and chemotherapy, which is only necessary in diseases such as the

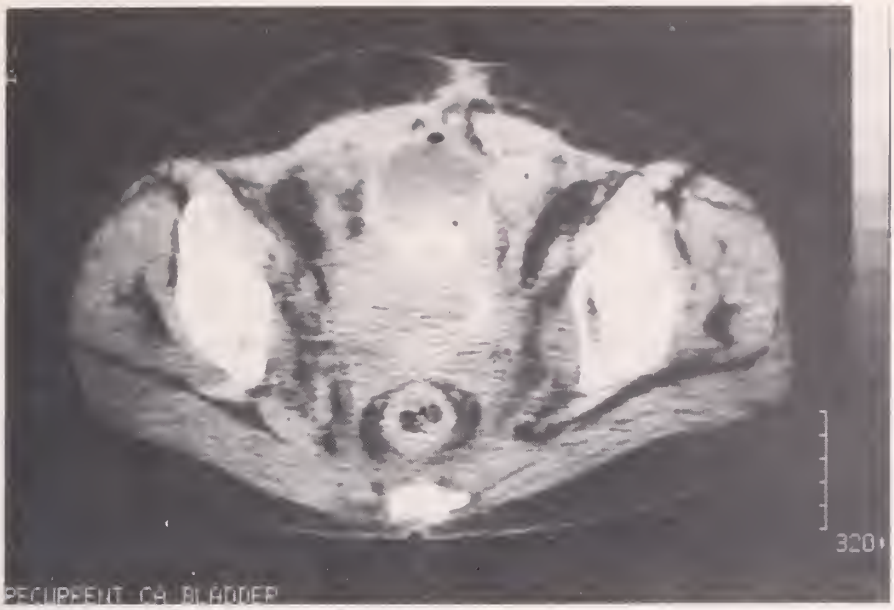

Fig 2.—Transverse CT image of the pelvis following contrast enhancement reveals a mass arising from the left lateral aspect of the wall of the bladder. The main component of the mass is intraluminal. There is no significant extravesicular extension of the mass.

common rhabdomyosarcoma of the bladder. Because of the nonspecificity of sonography and initial pathologic examination, radical excision should not be performed initially.

The presented case illustrates the need to consider the diagnosis of inflammatory pseudotumor of the bladder in children with hematuria. The lesion is easily identified with sonography, although biopsy is required for a definitive diagnosis. A better understanding of the true nature of IPT would be most helpful, but for the practicing urologist, an awareness of the process has obvious clinical importance.

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Cervical cancer radiation injury to the urinary bladder and ureters: management by cecal augmentation to a previous ileal augmentation cystoplasty

J.S. Mayersak, MD; Carl J. Viviano, MD; and Joseph W. Babiarz, MD, Wausau

A case report of the management of severe post cervical carcinoma pelvic radiation injuries is presented. Management was accomplished by detubularized ileal augmentation cystoplasty followed by cecal augmentation to the detubularized ileal augmentation 4 years later when bilateral ureteral obstruction developed. The development of a vesicouterine fistula required the creation of a large bowel cecal conduit for cutaneous urinary diversion utilizing the cecal augmentation antireflux segment.*Wis Med J.1995;94(5):300-304.*

Treatment of cervical cancer with radiation therapy presents long-term urological complications. These complications often present many years after the initial radiation therapy. The patient may develop an extremely small bladder capacity associated with urinary incontinence and excessive frequency. The treatment of this problem has included urinary diversion or augmentation cystoplasty with urethral sling procedures to prevent incontinence. Usual conservative procedures for urinary incontinence in these patients are doomed to fail. Retropubic urethropexy, catheter drainage and intermittent catheterization are not successful modalities of management for the small dysfunctional urinary bladder with a storage capacity of less than 100 cm^3. Management of these radiation complications is difficult and complicated. Individualizing treatment for each patient is mandatory.

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Case report

In 1976, a 42-year-old woman had completed 46 Gy of external beam and 50 Gy of intracavitary radiation therapy for invasive grade 3/4 squamous cell (large cell, non-keratinizing type) carcinoma of the uterine cervix, stage IB. In 1985, at age 51, gross hematuria and severe abdominal pain occurred. Augmentation detubularized ileal cystoplasty was performed because of a small, contracted, dysfunctional urinary bladder (Fig 1).[1]

Bilateral ureteral obstruction secondary to radiation-induced injury presented in 1988. Augmentation of the previous ileal augmentation cystoplasty graft was accomplished utilizing a cecal segment. Antireflux ureteral reimplantation was accomplished into the ileal stump of the cecum segment (Fig 1).[2] Renal ultrasound and intravenous pyelography demonstrated improvement (Figure 2a, Figure 2b).

Numerous episodes of gross hematuria occurred over the next several years. A CAT scan in 1991 demonstrated extensive fibrosis posterior to the urinary bladder wall corresponding to the remnant of the uterus (Fig 3). Ultrasound-guided transrectal needle biopsies of the retrovesical mass lesion did not demonstrate any recurrent uterine cancer. Barium enema and colonoscopy demonstrated progressive fibrosis and stricture of the sigmoid colon. A vesicouterine fistula developed, along with uncontrollable incontinence.

The patient underwent cutaneous urinary diversion in 1992. The cecal augmentation segment was detached from the ileal cystoplasty bladder graft. The tubular cecal segment was rotated cephalad and brought out through the skin as a cutaneous colonic urinary diversion. This allowed for the maintenance of the antireflux portion of the ureteral implantations into the ileal segment of the cecal augmentation graft. The ileal augmentation graft segment was closed at the site of the removal of the cecal graft and left attached to the urinary bladder. Recurrent bleeding from the radiated urinary bladder remnant has remained a problem.

Comment

Radiation therapy injury to the structures of the pelvis causes late complications within the genitourinary system. Reduction of bladder compliance, detrusor instability, urinary incontinence, fistula formation and ureteral obstruction are some of the possible complications. Urodynamically, there is a reduction in the mean volume of first bladder sensation after radiotherapy.[3] Perez, in a retrospective analysis of 811 patients treated with intracavitary and external beam radiation, reported 8% grade 3 complications following treatment.

Grade 3 complications usually require surgical intervention; they may consist of rectovaginal fistula, sigmoid stricture, small bowel obstruction, vesicovaginal fistula and ureteral stricture. With radiation

doses above 80 Gy the incidence of complications increased significantly. Urinary complications usually occur within 48 months following initial therapy.[4] These radiation complications do not affect patient survival rates. Women over 50 years of age had a slightly higher complication rate.[5] Intractable bladder hemorrhage in patients who are unsuited for cystectomy represents a late complication of pelvic irradiation.[6] In 132 patients with carcinoma of the cervix treated with external beam doses higher than 50 Gy, Stryker reported a fistula rate of 9%. Some patients had both vesicovaginal and rectovaginal fistulas. Severe rectal and bladder injuries were more common in stage IIIA and IIIB disease.[7]

Long-term bladder dysfunction consisting of urgency, urge incontinence, frequency, stress incontinence and nocturia is found 5 to 11 years after radiotherapy for cervical carcinoma in over a third of women treated.[8] There is a strong correlation between the size of dose per fraction and the risk of late complications involving the rectum and the rectosigmoid in the management of carcinoma of the cervix.[9] Lee felt that with radium therapy the dose-rate rather than the treatment time is the important factor in the risk of postoperative complications.

Clinically significant ureteral injury may develop from relatively small regions of high dose and dose rate.[10] The MD Anderson group reported a 10% incidence of severe complications in patients treated with 50 Gy whole pelvis irradiation plus radium. Complications were associated with unilateral parametrial boosts and with protruding vaginal radium sources.[11] Patients with metastatic tumor in the pelvic lymph nodes had a higher incidence of ureteral stricture.[12] Montana reported the risk of radiation-induced cystitis and proctitis was significantly greater when the radiation dose was greater than 8001 cGy.[13] Pre-existing hypertension or diabetes mellitus was associated with a higher incidence of related injury.[14] A single radium application contributes significantly to the major complication rate.[15]

Management of long-term complications can be extremely difficult because of the compromised blood supply to the structures in the pelvis and the progressive nature of the radiation fibrosis. Urethral sling procedures and augmentation cystoplasty offer an opportunity for a cure of the contracted urinary bladder associated with intractable urinary incontinence. Zoubek reported on 11 patients with serious radiation complications which occurred 3 to 39 years after radiation therapy and performed augmentation cystoplasty in five patients.[16] Urinary cutaneous diversion utilizing bowel segments has also been performed.[17,18]

Taylor and associates reported that abnormalities following radiation therapy most commonly occurred in the urinary tract. Hydronephrosis, which was bilateral in 17% of the cases due to distal ureteral stricture formation, was the most frequent finding. The develop-

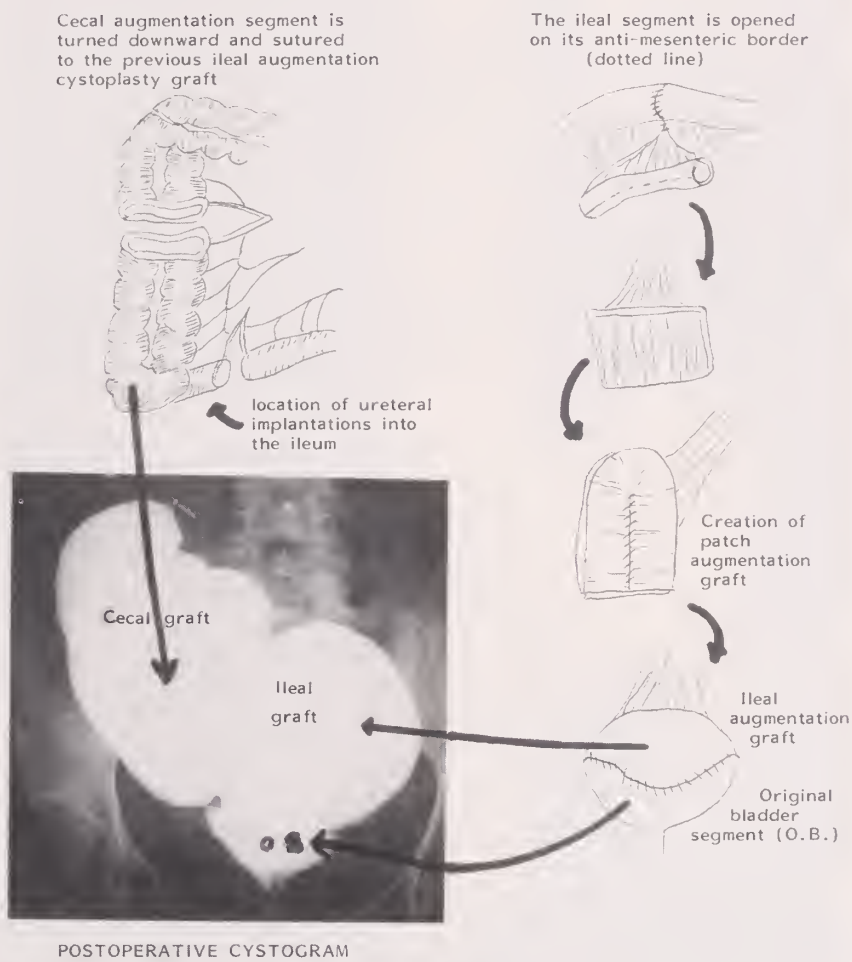

Fig 1.—Appearance of the postoperative bladder cystogram showing which segment of the neobladder originated from the detubularized ileal augmentation and which originated from the cecum augmentation to the ileal patch graft. The original bladder segment (labeled OB) can be seen to be quite small (see Fig 3 postoperative cystogram).

ment of high ureteral strictures not secondary to recurrent iliac lymph node tumor metastasis was felt to represent a new finding.[19]

Periureteral fibrosis caused obstruction more than 2 years after the completion of radiation therapy. Ureteral obstruction occurred at varying intervals after therapy; the longest interval was 14 years. Unilateral obstruction was more often due to fibrosis rather than recurrent tumor. Recurrent tumor was associated with ipsilateral leg edema and sciatic pain as well as hydronephrosis.[20]

Among the 328 patients reported on by Parliament the median time to ureteral obstruction was 26 months, with a range of 7 to 60 months. Ureteral obstruction was unilateral in 80% of the cases. The only risk factor associated with ureteral obstruction was the initial stage of the disease. Treatment consisted of ureterolysis, ileal conduit, transureteral ureterostomy and laparotomy.[21] Delayed obstruction of the ureter is not related to the initial location of the lesion in the cervix.[22]

Long-term follow-up is necessary in these patients because of the known association of second primary malignancies after the treatment of cervical cancer with radiation. The occurrence of these secondary tumors tends to be lO or more years after therapy, but the patient remains at risk for more than 30 years.[23] An adenocarcinoma of the large bowel and a transitional cell carcinoma of the bladder occurring 40 years after radiation therapy for carcinoma of the cervix was reported by Gatzen.[24] Boice and associates, in an international cooperative study of 150 000 patients, demonstrated an increased risk of cancer of the bladder, rectum, vagina, possibly bone, uterine corpus and cecum in patients treated with radiation for carcinoma of the cervix. The highest relative risk was for primary bladder cancer.[25]

Fig 2A.—Intravenous pyelogram April 1988 showing marked improvement in the upper urinary tracts with cecum augmentation to the ileal augmentation cystoplasty.

Discussion

We present a case report of a patient initially managed with ileal augmentation cystoplasty for treatment of a contracted urinary bladder from previous radiation therapy for carcinoma of the cervix. The patient developed bilateral ureteral obstruction 4 years later—11 years following initial radiation therapy. A cecal augmentation of the ileal augmentation cystoplasty was performed with implantation of the ureters in an antirefluxing fashion. Intermittent bleeding from the radiated urinary bladder is a persistent problem. The patient developed a vesicouterine fistula which was treated by utilization of the cecal augmentation segment to create a tubular cutaneous cecal urinary diversion.

Take down of the cecal augmentation of the ileal detubularized augmentation cystoplasty and the cre-

ation of a large bowel cutaneous diversion allowed for preservation of the antirefluxing ureteral implantations of the cecal augmentation. This type of solution to the radiation problem seems to initially be more desirable for the patient than cutaneous diversion. An argument can be made for performing initial continent cutaneous urinary diversion in younger patients with severe grade 3 radiation complications.

Radiation problems, unpredictable with regard to the time and certainty of their occurrence, create a difficult progressive management spectrum over a long period of time. With the possibility of the development of a second primary malignancy, the patient who has had radiation therapy for carcinoma of the cervix requires lifelong observation and management at appropriate intervals. The ingenuity of the urologist and the gynecologist is greatly challenged in the long-term management of the urinary tract in these patients.

Fig 2B.—Retrograde cystogram December 1992 demonstrating no ureteral reflux to be present. Bladder capacity is 600 cm³ with pressure of 17 mL water.

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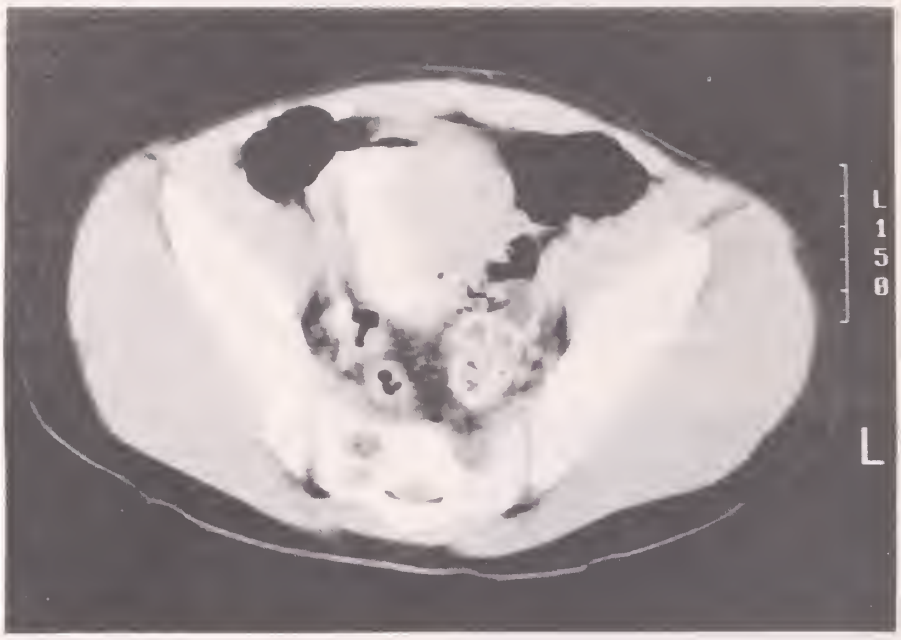

Fig 3.—Computerized axial tomography study May 1991 demonstrating cecal augmentation to previous ileal augmentation cystoplasty with extensive fibrosis posterior to the bladder wall corresponding to remnant of the uterus.

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Breast cancer screening complacency and compliance

William J. Maurer, MD, Marshfield

An HMO initiative designed to increase the compliance rate for the preventive service (mammography) is described. By looking at Security Health Plan charge data and sending a letter of notification when women are not up-to-date on their screening mammography, we were able to increase the mammography compliance rate from 47% to 72%. This system is designed to supplement the preferred method of recommendations by the primary care physician aided perhaps by a chart reminder system. Some problems with the methodology are described.*Wis Med J.1995;94(5):305-306.*

THE VALUE OF mammography as a screening procedure in women at a higher risk for breast cancer as well as for women in selected age groups is well established.[1,2] In spite of the acceptance of this screening procedure's benefit by virtually all primary care physicians, and even after many years of encouraging this procedure to women through the popular press, the national mammography compliance rate was estimated by the National Cancer Institute to be between 25% and 41% in 1990.[3] This variation is due to different compliance rates in the various parts of the country surveyed. More recent surveys in Wisconsin have shown that 62% of women who should have undergone a mammography have had one in the past two years. However, the rate varies when education, annual household income, and county of residence are compared. It is encouraging that national rates of women who have had a mammogram at some time in their life are increasing. In Wisconsin, the percentage of women age 40(+) who have had at least one mammogram increased from 52% in 1987 to 77% in 1992.[4]

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It is apparent that, despite acceptance of this procedure by physicians, a considerable number of women for whom mammography is recommended are not up-to-date with this preventive measure. The preventive health service recommendation (Healthy People 2000) has set a goal that 80% of women age 50 to 70 would have annual breast exams and mammograms.[5] In this paper I will describe an HMO initiative and a technique that can identify the compliance rate of a targeted population and, through intervention, effect a significant improvement.

Security Health Plan is an 80 000-member HMO in North Central Wisconsin. Security Health Plan's preventive service initiative identified, through an analysis of charge data, all women over age 40 who were not up-to-date with mammography screening.

Although there are conflicting protocols and less consensus figures for this procedure in women under age 50 and above age 75, there is little disagreement about its indication for women between age 50 and 65. While our project was more inclusive, I will describe the results for plan participant women between age 52 and 64.

In 1993 Security Health Plan queried our data system and found that our total population of women between age 52 and 64 was 3224. Of that number, 1542 (47%) were found to be up-to-date with recommended mammography screening (having had the procedure within the past two years). Following this, the Security Health Plan Medical Director sent a letter to the women identified as not being up-to-date on their mammography screening. This letter gave the recommendation that the participant call her physician either to find out if for some reason a mammogram was not indicated, or to remind the physician to schedule the procedure.

In 1994 we resurveyed this same targeted population of women between age 52 and 64 and found that the 47% compliance rate on this screening procedure had increased to 72%.

We identified a number of problems arising from the use of charge data, which tended to fall into four categories: physicians and staff feeling that they hadn't been notified about the project, questions regarding the efficacy of the procedures, our notification to people who did not need the service, and finally, our notification to people who had already undergone the service but whom we had failed to identify through our data systems.

A numher of physicians asked why we did not notify them rather than the patient. Many subscribers do not have identifiable physicians and our data did not allow us to determine the attending physician in all cases. We did notify attending physicians of problems inherent in our data system and apologized for any communication problems we may have caused with their patients.

There were a number of calls regarding the conflicting guidelines, especially after age 65.

Because of the charging system we notified a number of people who had already undergone the preventive service. In some instances Medicare paid in full and we received no

bill; a few appointments occurred around the time our notification letter went out; and finally, sometimes there was a failure to charge for the procedure.

The largest number of calls occurred when we notified people who, while they had not had the procedure, really didn't need it. This included patients who were sick with other more serious problems, such as disseminated malignancy. There was a feeling that the notification interfered with the patient's trust in their physician.

Finally, some concern was expressed regarding the possibility of violating patient confidentiality by doing chart reviews. However, we used charge data and did not look at individual charts.

Despite health insurance coverage for this procedure, which should eliminate any financial barrier, one fourth of our Health Plan population are still not up-to-date on this screening procedure and we need to identify the reasons for this. While increasing this preventive screening procedure is a worthwhile goal, the ultimate benefit of this initiative is the early detection and cure of breast cancer.

Current statistics indicate that approximately one third of the US population is now enrolled in an HMO product. Since this type of initiative is not unique to Security Health Plan but is generally encouraged and even required by HMOs wishing to be certified by the National Committee for Quality Assurance, one would expect a higher rate of compliance by the HMO-enrolled population as a result of the initiative described in this paper.

The National Committee for Quality Assurance, who provides credentials to qualifying HMOs, uses HEDIS data (Health Plan Employer Data and Information Set) and requires health plans to encourage and know the preventive services status of their participants. Indeed, these types of initiatives are required by state agencies and employers as a mark of quality.

While we have heard of patients who had their cancer diagnosed as a result of the preventive service associated with our initiative, it remains to be seen if a lowered morbidity and mortality rate will be achieved in our health plan population.

Initiatives such as this, coupled with continuing patient education and a chart reminder system for physicians, will help. All agree that the most powerful encouragement is a personal recommendation from the attending physician.[6-8]

Acknowledgement

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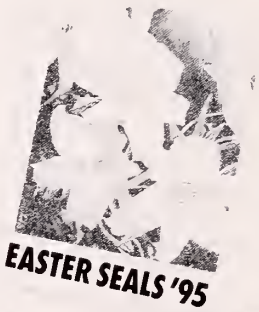

Easter Seals

Public health

Mid-Course Review: A Progress Report on the Healthier People in Wisconsin Year 2000 Agenda

The Wisconsin Division of Health, Bureau of Public Health has published the *Mid-Course Review: A Progress Report on the Healthier People in Wisconsin Year 2000 Agenda*. This document represents a summary of the findings in the comprehensive version of the Mid-Course Review, which will be broadly distributed as part of a public review and comment period during late Summer 1995. The following summary was taken from the full 37-page report.

Recognizing that the Public Health Agenda is the document that guides public health practice in Wisconsin, a mid-course review is essential to measure our progress toward meeting the Agenda objectives. From this review Wisconsin communities will collectively be able to reflect on accomplishments to promote health, prevent disease, and protect the environment for residents. As a state, we will also be able to make adjustments in public health planning efforts to assure the goals identified in the Agenda are met by 2000.

The development of *Healthier People in Wisconsin: A Public Health Agenda for the Year 2000* and the *Mid-Course Review Progress Report* demonstrates continuing efforts on the part of governmental public health departments to work in collaboration with public, private, and voluntary sectors throughout the state to carry out the core public health functions of assessment, policy development, and assurance. In so doing, together we can continue to move forward toward a healthier Wisconsin.

Background

In 1989, Wisconsin identified major statewide health concerns and issues through a planning process involving professionals and consumers of services from various sectors of the state. Diverse teams comprised of more than 150 participants met over the course of 11 months to draft a plan that addressed goals and objectives in the following areas: communicable diseases, chronic disease prevention and control, injury prevention, environmental health, reproductive and perinatal health, infant and child health, and adolescent health. The culmination of this effort, *Healthier People in Wisconsin: A Public Health Agenda for the Year 2000*, has served as the road map for the provision of public health services, guiding the direction and focus of public health in Wisconsin.

Seven *Healthier People in Wisconsin* planning teams developed the objectives as standards that individuals and organizations should strive toward collectively to ensure quality public health services. The Agenda is the plan for attaining the health aspirations of our Wisconsin community. During the past 5 years, people representing multiple disciplines have worked toward meeting the goals and objectives delineated in *Healthier People in Wisconsin*.

Various organizations have used *Healthier People in Wisconsin* in the development of health services. At the state level, this Agenda is used to provide direction and set priorities in allocating resources, providing technical assistance, and collecting health-related data. Furthermore, the Agenda stimulates and

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The public health column is not reviewed by the *WMJ* Editorial Board. This report is taken from a publication entitled *Healthier People in Wisconsin Mid-Course Review: A Progress Report on the Healthier People in Wisconsin Year 2000 Agenda*. This document was released to the public at the Wisconsin Public Association Meeting on June 2, 1995 in Madison. Copies of the full 37-page report may be obtained from Kenneth Baldwin, Director, Bureau of Public Health, 1414 East Washington Avenue, Madison, WI 53703. Copyright 1995 by the State Medical Sociey of Wisconsin.

Progress toward reaching the *Healthier People in Wisconsin* objectives

Section	Objective has been met	Progress is being made	Progress is not being made	Data are not currently available.	Total
Communicable Diseases	10 (20%)	17 (34%)	8 (16%)	15 (30%)	50 (100%)
Chronic Disease Prevention	3 (4%)	26 (34%)	23 (30%)	24 (32%)	76 (100%)
Injury Prevention	8 (14%)	20 (36%)	6 (11%)	22 (39%)	56 (100%)
Environmental Health	5 (15%)	24 (71%)	3 (9%)	2 (5%)	34 (100%)
Reproductive/Perinatal Health	4 (11%)	22 (61%)	5 (14%)	5 (14%)	36 (100%)
Infant and Child Health	2 (5%)	20 (50%)	0 (0%)	18 (45%)	40 (100%)
Adolescent Health	1 (4%)	14 (48%)	9 (31%)	5 (17%)	29 (100%)
TOTAL	33 (10%)	143 (45%)	54 (17%)	91 (28%)	321 (100%)

fosters collaboration among agencies identified in the implementation steps, with each agency having a vested interest in seeing the objectives met.

At the local level, health departments and other community-based organizations use the Agenda as a resource to provide baseline data to measure progress in their communities in specific areas of need. The Agenda has also served as a guide for the provision of health services in communities throughout the state.

This year marks the midpoint of this 10-year plan, prompting Ann J. Haney, the Division of Health administrator, and Kenneth Baldwin, Bureau of Public Health director, to commission a mid-course review of Wisconsin's progress in meeting the Agenda's objectives. While many local organizations have monitored the progress of portions of the Agenda, this is the first effort aimed at providing a snapshot of statewide progress. The mid-course review will provide valuable information to communities as they implement local needs assessments such as the APEX*PH* (Assessment Protocol for Excellence in Public Health) and Family Preservation and Family Support initiatives.

Methods

Bureau of Public Health staff reviewed all 321 *Healthier People in Wisconsin* objectives to determine and report current progress made toward achieving each objective. Objectives in the original document are either quantitatively or qualitatively measurable. Staff collected and analyzed data available up to April 1995, to critically evaluate the extent to which each objective has been addressed.

After the available data were collected and evaluated, staff commented on the data trends. All commentaries will be available as part of the comprehensive *Mid-Course Review* which will be disseminated as part of the public review and comment process. Each of the objectives was then placed into one of the following four categories which mirror the progress categories used to report on the *National Healthy People 2000* objectives.

- *Objective has been met.* The data indicate the objective has been met or exceeded.
- *Progress is being made toward meeting the objective.* Available data suggest that the objective will likely be met by 2000 or that some discernable progress is being made in the direction of the 2000 objective.
- *Progress is not being made toward meeting the objective.* Available data indicate no discernable progress has been made toward reaching the objective or there is a trend in the opposite direction.
- *Data are not currently collected in Wisconsin to measure this objective.* There are no data available to the Division of Health (DOH) to measure progress on the objective; there may be non-DOH resources for these data which will be revealed in the public review and comment period.

Summary of results

While some people may have anticipated that Wisconsin would achieve all 321 of these objectives, this was not the purpose of the plan. The framers of the 1989 *Healthier People in Wisconsin* document set high standards for each objective, understanding that some objectives would not be fully met and that surveillance systems would need to be developed for others. Overall, 10% of the objectives have been met, progress is being made for another 45%, there is no progress for 17%, and no data are available for 28% (see table).

Next steps

Recognizing that the Public Health

Agenda is the document that directs public health practice in Wisconsin, it is critical that we conduct a mid-course review to measure our progress. From this review we will be able to reflect on our accomplishments to promote health, prevent disease, and protect the environment for residents. We will also be able to make adjustments in our public health planning efforts to assure the targets identified in the Agenda are met by 2000.

We encourage you to participate in the public review and comment period of the mid-course review. You are welcome to sign up to serve on one of seven work teams which will review comments and make revisions to the *Mid-Course Review*. For more information or for a copy of the Mid-Course Review, please contact Kenneth Baldwin, Director, Bureau of Public Health.❖

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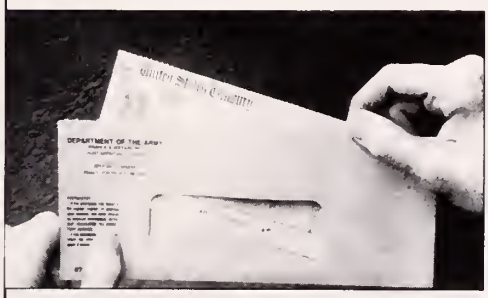

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Second in a series.

Practical considerations regarding ethical questions in the daily practice of medicine

Maria Van Cleave, SMS Commission on Medicine and Ethics staff

Under the leadership of the late JD Kabler, M.D., the Commission on Medicine and Ethics decided to publish a series of articles on real-life ethical situations that frequently confront physicians in their daily practice. The first article (*WMJ*, March 1995) discussed the ethical responsibility of physicians who become concerned that a colleague is, on some level, incompetent or impaired. The commission also discussed managed care guidelines and various ways that physicians might deal with practice parameters and limitations on treatment lengths which they feel might be detrimental to their patients. This article will focus on two additional vignettes.

Vignette 1

During a conference on chronic noncancer pain, one physician remarks, "I send them to an alternative health care practitioner. I don't think it does them any good, but it gets them out of my office." What are the ethical considerations here?

An interesting aspect of focusing on very specific ethical questions is that each individual confronted with the situation may have a slightly different emphasis on its ethical solutions. While strict consensus is sometimes difficult to attain, in this situation, the members of the commission all agreed that the most unethical part of the statement was the part that says, "it gets them out of the office." Armond H. Start, MD, summed it up succinctly. He said, "A physician is ethically obligated to act in the best interests of his/her patients. To refer a patient to a practitioner "to get them out of my office" must be vigorously challenged and the physician publicly reprimanded at the conference."

Physicians on the commission had some differences of opinion about referring patients to alternative practitioners in the first place. Rod Sorenson, MD, felt that a referral such as this "causes an unnecessary waste of medical resources, undermines faith in physicians and may 'legitimize' quackery." R.A. Dart, MD, and Kathryn Nichol, MD, felt that further discussion with the patient would be important in this situation.

Dr Dart stated that physicians should admit their inability to deal with the problem. They "should express concern for the patient, advising the patient of their desire to assist in seeking greater expertise in management."

Dr Nichol added, "If, in fact, the physician does not feel there is anything within his or her purview to help the patient, the patient has a right to know that. It may then be appropriate for the physician to describe some of the alternatives available including discussion of documentation of benefit to patients. That would at least allow patients an opportunity to discuss the fact that we as physicians do not always have answers and cannot always help patients improve their health status. But, at least in this manner the patient is involved with the decision making and recognizes some of the risks and shortcomings of the offerings."

Michael Cross, MD, and Charles Junkerman, MD, stressed the combined issues of the physician-patient relationship, informed consent and patient autonomy. Dr Junkerman noted that, "the relationship between doctor and patient should be built on trust. The patient trusts that all the doctor's recommendations will be made honestly and in good faith for the benefit of the patient. This doctor negates that trust in making a referral that he personally does not believe will help the patient. Informed consent -- another important principle -- becomes impossible because the patient has not been given accurate and candid information."

Dr Cross said, "Patient autonomy is at issue also. The physician, by not revealing the probable futility of this referral, is not allowing the patient to decide whether this a good move. Paternalism without beneficence or non maleficence has bypassed patient autonomy."

Vignette 2

The Medical Assistance program reimburses recipients for rides on specialized vehicles as long as a physician certifies that the rides are medically necessary. A physician new to a group practice notices that other physicians routinely sign documents for patients without asking questions. The physician then discovers that at least one patient is requesting and receiving certification for rides unrelated to medical care.

Once again, in this situation, members of the Commission on Medicine and Ethics held varying points of views. Doctors Start and Cross called the physicians in question guilty of neglect. Dr Start went further in suggesting that not establishing the need for specialized vehicles and documenting in the medical record the facts of the functional impairment" were perhaps, indica-

tors of fraud. Dr Cross, on the other hand, concluded that, "The real culprits are not the physicians. They can be accused of inattention to paperwork, not fraud, where as the patient is clearly misusing services and misleading a busy physician."

The real ethical dilemma described in the second vignette, however, relates not to the physician who is signing the dubious travel vouchers but to the new physician who discovers this practice. What should he do? Most of the physicians on the commission felt it would be best to discuss the question as an overall matter of policy rather than accuse a specific individual of any particular misdeed.

Steven H. Cohen, MD, wrote: A physician new to a practice may feel somewhat ill at ease in challenging the practice patterns of a senior associate. He may want to "bounce the idea" off other office staff, such as nurses or the office manager, in a non-challenging manner such as "Does the office have a policy about medical transportation approval?" He may want to approach the physician in question asking, "How do you handle certification of transportation?" The true factors may be unknown to the ordering physician and approval may be withdrawn. This may lead to a policy about determining appropriateness and need for this form of ancillary care.

Dr Sorenson agreed with this assessment and added, This "new" physician is obviously in a difficult spot. It seems clear from the way the vignette reads that he is not supportive of the idea of unauthorized use of government paid travel vouchers. His first responsibility would be to not personally participate in this fraud by refusing to sign documents for inappropriate or questionable travel requests. Once he is able to have a larger influence in his group he should communicate his concerns to the other members of his practice - as a group as opposed to individual physicians. In this way no specific physician will be put on the spot and he will be less likely to be labeled as a "troublemaker." There may actually be no malice intended by the other physicians but simply carelessness in not checking carefully that the travel vouchers are being used appropriately. The troubled physician would have to determine himself if an individual patient is being blatantly dishonest in his requests for transportation and that could even require reporting to the appropriate agency."

Obviously, in ethics, it is difficult,

Continued on next page

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Continued from previous page
if not impossible, to determine a "correct" answer. The "opinions" expressed in this article are just that. They do not reflect the official policy of the State Medical Society of Wisconsin. Those seeking further information may wish to consult the American Medical Association's 1994 Code of Medical Ethics, number 3.04 on Referral of Patients. Additionally, the 1993 AMA Policy Compendium lists several policies on Medical Review and Medical Necessity Determinations. The commission urges those who read this article to consider these vignettes for themselves and to weigh their own values and priorities as they determine their own ethical judgements.❖

The word from WIPRO
New column gives monthly look at WIPRO's quality improvement projects

Jay A. Gold, MD, JD, MPH, Madison

As most physicians realize, a nationwide shift has taken place in peer review, under the rubric of the Health Care Quality Improvement Program (HCQIP). This was spelled out in some detail in the May 1994 *Wisconsin Medical Journal*. To reiterate briefly: the review of randomly selected charts for substandard care in Medicare admissions, which had occasioned considerable animosity among Wisconsin physicians, has substantially ceased. The only Title 18 chart review that continues is in the areas of beneficiary complaints, hospital-issued notices of noncoverage, and ambulatory surgery. At the Wisconsin Peer Review Organization (WIPRO), the focus now is on working cooperatively with practitioners and providers in order to improve care by analyzing patterns of care. This column, *The Word from WIPRO*, will provide *WMJ* readers with a monthly look at the PRO's quality improvement projects.

A WIPRO project begins with identifying an opportunity for improvement--that is, a clinical area where the condition is frequent in the Medicare population; where there exists a reasonably well-defined and accepted consensus in the medical community, based on published literature, as to what constitutes appropriate care; where there is a substantial, clinically important difference between the consensus and actual practice; and where methods are available to measure improvement in practice.

Each project is advised by a study group constituted of local experts, and all projects are overseen by a steering committee consisting of representatives of the medical profession, health care organizations, other experts, and consumers in Wisconsin. Membership on these committees is open to Wisconsin physicians.

Continued on next page

Current and proposed WIPRO study areas
Breast conserving surgery
Hip replacement surgery
Radical prostatectomy
Red cell transfusions
Community-acquired pneumonia
Bilateral cardiac catheterization
Prophylactic antibiotics in surgery
Warfarin in atrial fibrillation
Inpatient coding
Treatment of DVT
Medication errors
Postoperative pain management
Sepsis
Inappropriate medications
Anticoagulation monitoring
ACE inhibitors in diabetic nephropathy
Pressure ulcers
IPPB
Emergency room asthma management
Pneumococcal and influenza vaccination
Depression
Knee replacement
Alzheimer's caregivers

The word from WIPRO is not reviewed by the *WMJ* editorial board. Dr Gold is WIPRO's Principal Clinical Coordinator. He also serves as Assistant Clinical Professor of Preventive Medicine and Bioethics at the Medical College of Wisconsin, and as Senior Lecturer in Preventive Medicine at the University of Wisconsin, Madison. Reprint requests to Jay A. Gold, MD, JD, MPH, WIPRO, 2909 Landmark Place, Madison, WI 53713.
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Providers are invited to collaborate on projects initiated by WIPRO or suggested by the provider. Usually, once collaborators for a project are identified, indicators are developed in conjunction with the Study Group, data are collected from a number of charts from each collaborator, and rates are calculated for each provider for each quality indicator; a statewide rate also may be calculated. The analysis is communicated to our collaborating partners, who then work with us to develop a plan to improve care. Once collaborating hospitals implement their improvement plans, further data are gathered and analyzed, in order to determine whether care has been improved, and perhaps to suggest further improvement efforts. It is the use of quality indicators to measure opportunity for and success of improvement that distinguishes HCQIP.

WIPRO already is spearheading projects in many diverse clinical areas, and is adding more each month. Every Wisconsin hospital already has participated in some form in the Cooperative Cardiovascular Project, a pilot project that now is being implemented nationwide. Other areas in which we are working or planning to work with collaborators at present are listed in the table; 60% of Wisconsin hospitals have collaborated in at lease one of these projects.

This monthly *WMJ* column will be used to inform Wisconsin physicians of what has been learned from our projects so that they may introduce improvements into their own practices. We also see it as a way to establish a dialogue with the medical community, something we invite and encourage. Let us know your comments on any aspect of our work: they will be considered seriously.❖

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July 31-August 4, 1995		
Session III	Alan J. Rawitz, MD	"Brief Psychotherapy With Children and Adolescents"
Session IV	Judith Jordan, PhD	"A Relational Model of Women's Development: Therapy and Clinical Applications"
Sesion V	Robyn S. Shapiro, JD Arthur R. Derus, MD, JD	"Bioethics in the Age of Managed Care"
August 7-11, 1995		
Session VI	Donald Melchenbrum, PhD	"Post Traumatic Stress Disorder (PTSD) in Adults and Children"
Session VII	Peter L. Brill, MD Len Speery, MD, PhD	"Corporate Therapy and Consulting"
Session VIII	L. Cass Terry, MD, PhD Ross M. Dotson, MD Safwan Jaradich, MD Eric F. Mass, MD George L. Morris, III, MD	"Neurology for Non-Neurologists"

For more information, please contact: Carl Chen, MD, Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, WI 53226 (414) 257-5995.

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Joint Finance Committee axes $300 provider tax and Medicaid 'best price' requirement

The Joint Finance Committee has voted to remove a $300 biennial provider tax out of the 1995-97 state budget. The $300 fee was to be levied on all actively licensed podiatrists, chiropractors and physicians, including retired physicians. State Rep. Steve Foti (R-Oconomowoc) worked with the SMS and proposed the motion to remove the fee, which eventually passed the committee in a 10-6 vote. State Rep. Sheila Harsdorf (R-River Falls) defended the motion during Committee debate and stated that the physicians in her district who contacted her were all opposed to the tax.

The fee as proposed by Gov. Tommy Thompson's budget was expected to generate $8.6 million during the 1995-97 biennium. Of these monies, only $3.6 million was going to be used to fund Medicaid reimbursement increases, while the remaining $5.1 million was going to be used to reduce property taxes around the state.

The removal of the $300 tax means physicians, podiatrists, and chiropractors will probably not see a Medicaid reimbursement increase. The Governor originally proposed using the tax to fund a 2.5% increase for physicians, 6.75% for chiropractors and 6.25% increase for podiatrists. Because of inaccurate budget assumptions made by the Governor, the actual increase to physicians would have only been 1.75% in 1996 and 1.5% in 1997.

The Joint Finance Committee also voted to remove the Medicaid "best price" requirement proposed by Gov. Tommy Thompson. This proposal was expected to save the state more than $8 million and would have required all non-institutional providers, including physicians, to bill Medicaid at the lowest price accepted by the provider as payment for any service during each month. The proposal would have significantly increased the amount of paperwork for physicians and clinics, even though the Department of Health and Social Services admitted they would not save any money from physician clinics. ❖

HCFA denies single payment geographic area for Wisconsin

The SMS request to convert Wisconsin to a single statewide payment area under the Medicare physician fee schedule has been denied again. With only 34% of the physicians supporting a state single payment locality who live in counties estimated to receive payment decreases, there continues to not be overwhelming support among physicians for a conversion to a single payment area.

Of other states who have been approved by HCFA for a statewide payment area, the lowest percentage of support among physicians in losing counties has been 60%. The 34% number came from a survey the SMS sent in April to all seven counties (Dane, Kenosha, Milwaukee, Ozaukee, Racine, Washington and Waukesha) which would have a decreased geographic adjustment factor if the request was approved.

At the December Board of Directors meeting, the board reaffirmed its support of a single Medicare payment area for Wisconsin and requested HCFA reconsider the SMS application for a single payment area.❖

WIPRO discontinues physician attestation review

HCFA has notified WIPRO of a change in monitoring physician attestation statements. Effective immediately, PROs will no longer perform physician attestation review. HCFA is shifting the responsibility for attesting to the accuracy of diagnoses and procedures related to DRG classification under the Medicare hospital prospective payment system from the physician to the hospital. Regulation 42 CFR 412.46 which outlines the requirements relative to physician attestations as a condition for payment under the prospective payment system has not been altered.

A physician attestation document is required for each discharge of a Medicare beneficiary regardless of whether Medicare is paying that particular bill (e.g. no pay bill). To summarize the regulation, "the attending physician must, shortly before, at, or shortly after discharge (but before a claim is submitted), attest to the principal diagnosis, secondary diagnoses, and names of major procedures performed."

The list of diagnoses and procedures must appear in the medical record and must be followed by the following attestation statement: "I certify that the narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge."

The above attestation statement must immediately precede the physician's dated signature. In summary, hospitals are required to fulfill Regulation 42 CFR 412.36, but WIPRO will no longer monitor compliance with this regulation. Need more information? Call Lois Kelley at WIPRO at 1-800-362-2320 or (608) 274-1940.❖

Chair of SMS board named Alumnus of the Year

Raymond C. Zastrow, MD, current chair of the SMS Board of Directors, has recently been selected 1995 Alumnus of the Year by the Medical College of Wisconsin-Marquette Medical Alumni Association. Donald P. Schlueter, MD, Alumni Association president, presented the award to Dr Zastrow on May 12 at the 1995 Alumni Banquet. Dr Zastrow, who is also a clinical professor of pathology at the Marquette Medical School, was selected from more than 9,000 medical school alumni for this prestigious honor. In addition, Dr Zastrow has recently been elected to head the College of American Pathologists, a national medical society which serves over 15,000 physician members worldwide. Dr Zastrow practices at St. Michael Hospital in Milwaukee and resides with his wife, Mary, in Hartland.❖

Raymond C. Zastrow, MD

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Dr Viste to head U.S. Practicing Physicians Advisory Council

Kenneth M. Viste Jr., MD, of Oshkosh, was recently appointed by Health and Human Services Secretary Donna Shalala to chair the Practicing Physicians Advisory Council. The 15-member council, established by Congress, meets quarterly to advise the HHS secretary on proposed changes in regulations and carrier manual instructions that relate to physicians' services under Medicare. The council helps to provide valuable input towards improving the department's regulatory process.

Dr. Viste, who has been a member of the Advisory Council since March, 1994, replaces Richard B. Tompkins, MD, from Rochester, Minnesota, who has led the council since its inception in 1992.

"Dr Viste is following in the footsteps of Dr Tompkins, who from the start has provided excellent leadership for the council," said Secretary Shalala. Dr Viste will serve a 2-year term as chair of the government advisory panel.

Dr Viste's appointment is reflective of his longstanding leadership role in medicine. He is a past SMS president and recipient of the highest SMS honor, the Directors' Award. He has long played an active role in the formation of public policy.

He has also been involved in the American Medical Association for more than 10 years, currently chairing the AMA's Council on Legislation. The council is responsible for providing legislative analysis and policy recommendations to the AMA Board of Trustees, drafting model legislation for use at both the state and federal levels. Dr Viste was SMS president from 1986-1987 and recently chaired a committee of the state society which developed a plan for universal health care coverage for all Wisconsin residents.

Kenneth M. Viste, Jr., MD

Along with his recent appointment to the Practicing Physicians Advisory Council, Dr Viste was also just recently elected President of the American Academy of Neurology during the Academy's 47th Annual Meeting in May. The organization represents 13,000 neurologists throughout the world and is based in Minneapolis. As president of the Academy of Neurology, Dr Viste would like to have a positive influence on the care of patients with neurologic disease.

"There is great hope and promise for patients with neurological disease, given the advances being made today during this Decade of the Brain," Dr Viste said. "I believe that we can help patients who now have difficulty gaining access to needed neurologic care."

Dr Viste currently practices neurology in Oshkosh and Fond du Lac, Wisconsin, and is also a medical director of three institutions, including a nursing home, and specializes in the rehabilitation of neurological patients in a community hospital-rural setting.❖

National tobacco expert Glantz to speak in Pewaukee

Stan Glantz, PhD, a nationally recognized tobacco expert from Stanford University and the author of several articles on the positive economic and health aspects of businesses becoming smoke-free, will be a featured speaker at a toabacco-control symposium Friday, Sept 22, at the Country Inn in Pewaukee.

Sponsored by the American Heart Association and the American Cancer Society, this forum will look at "Kids or Tobacco?: Wisconsin's Choice." Workshops will range from spokesperson training to deceptive advertising to the latest information on lawsuits against tobacco companies. For information, call Betsy Zera or Jennifer Wise at 1-800-947-0487.❖

Physician briefs

Dennis Biros, MD, has joined the Cumberland Memorial Hospital as a staff psychiatrist. For the past 22 years, he has been on the psychiatry staff at St. Francis Medical Center in La Crosse. A Minnesota native, Dr Biros earned his medical degree from the University of Minnesota in Minneapolis.

Chanderbahn Choithani, MD,* of Whitefish Bay, a specialist in general urology and urology oncology at Froedtert Memorial Lutheran Hospital, has been appointed assistant professor of urology at the Medical College of Wisconsin. Prior to his appointment, he practiced in Milwaukee's Northpoint Medical Group for 15 years. Board-certified in urology by the American Urological Association, he is a Fellow of the American College of Surgeons, the Royal College of Surgeons in Edinburgh, England, and the Royal College of Surgeons, Canada. He served a fellowship in urology at the University of Toronto and an internship and residency in urology at Memorial Medical Center in Savannah, Ga. He also received post doctoral training in general surgery and urology in England at Newcastle General Hospital, Stamford General Hospital in Midlands and Chase Family Hospital in Middlesex.

Anthony Dalton, MD, has joined the staff of the St. Croix River Valley Medical Center. Dr Dalton is a surgeon specializing in Orthopedics with a diverse background in the area of Sports Medicine. Dr Dalton practiced privately in Port Washington and also worked in rehabilitation through his own clinic, the Dalton Health Center. He also worked for two years with Occupation Health Clinics of America in Milwaukee. Since 1993, Dr Dalton had acted as Chairman with the Department of Musculoskeletal Medicine and Surgery Medical Arts Clinic of Dixon, Ill.

James Esswein, MD,* Family Practice physician at Midelfort Clinic's Cameron office, has been selected by the University of Wisconsin Medical Alumni Association as the recipient of the 1995 Ralph Hawley Distinguished Service Award. The award is given to an alumnus who has contributed to the local and/or national community and for other humanitarian activities. A physician in the Cameron area for 25 years, Dr Esswein has maintained many professional affiliations and served in several administrative capacities, while also participating in numerous civic and community activities.

Wayne Evans, MD, has been appointed assistant professor of OB/GYN at the Milwaukee Clinical Campus of the UW Medical School at Sinai Samaritan Medical Center. Dr Evans earned his medical degree at the Medical College of Ohio in Toledo. He completed his residency in OB/GYN at Good Samaritan Hospital, Cincinnati, Ohio. He also completed a fellowship in critical care medicine at the University of Maryland Medical Center/R.A. Cowley Shock-Trauma Center, Baltimore, Maryland, and in maternal-fetal medicine at the University of Pittsburgh School of Medicine/Magee-Women's Hospital, Pittsburgh, Penn.

Kevin Fullin, MD,* a Kenosha cardiologist and volunteer in the Domestic Violence Project, won a top prize in the JCPenney Golden Rule Award competition for 1995. The awards honor excellence in volunteer commitment in the Racine/Kenosha area, and are sponsored by JCPenney and the United Way. He was honored for his hands-on leadership which has made the project an innovator in providing direct services to victims of domestic violence within a health care setting, and in educating both professionals and the community about issues related to violence.

Terry L. Hankey, MD,* has been appointed to serve as chair on the American Academy of Family Practice Physicians Committee on Health Education. Dr Hankey, a past president of the Waupaca County Medical Society, affiliated his Waupaca-based medical practice with La Salle Clinic last year. He received his medical degree from the Duke University School of Medicine and served his family practice residency at the UW-Madison.

Richard G. Kardell, DO,* has joined the Marshfield Clinic-Chippewa Center. He earned his medical degree from the University of Medicine and Dentistry of New Jersey, School of Osteopathic Medicine in Stratford, New Jersey. He served his residency in otorhinolaryngology/oro-facial plastic surgery at the University of Medicine and Dentistry of New Jersey, School of Osteopathic Medicine and Kennedy Memorial Hospital, University Medical Center in Stratford, NJ.

William Listwan, MD,* president of the West Bend General Clinic, recently qualified as a certified Medical Review Officer. Dr Listwan was certified by an independent organization, Medical Review Officer Certification Council, which identifies and tests physicians with the highest professional standards and having practical skills to evaluate drug and alcohol tests in the workplace.

David A. Misorski, MD,* has joined the Aurora Medical Group primary care clinic at the Aurora Health Center in the Town of Pewaukee. Dr Misorski received his medical degree from the Medical College of Wisconsin, and completed his residency in family practice at Columbia Hospital. He is an assistant clinical professor of family and community medicine at the Medical College of Wisconsin.

Gina Pahm, MD, a family practitioner, has joined the staff of the Grant Community Clinic, Lancaster. Dr Pahm arrives as part of a joint recruiting effort by Lancaster Memorial Hospital, Grant Community Clinic and Dean/St. Mary's Regional Clinics. Dr Pahm graduated from the University of the Philippines College of Medicine, where she stayed on as an assistant professor within the college's community health program. She obtained her Wisconsin medical license from the UW-Madison and completed a one-year residency in internal medicine at the University of Illinois at Urbana-Champaign, College of Medicine. She did the rest of her

Continued on next page

County society news

Barron-Washburn-Burnett. The following physicians have been approved for membership in the Barron-Washburn-Burnett County Medical Society: Bruce E. Bray, MD; Laura B. Bray, MD; Gary R. Degerman, MD; Gwen D. Martin, MD; and Richard R. Sampson, MD.

Chippewa. The Chippewa County Medical Society met on May 15, 1995, at the Arizona's Restaurant at the Flame in Chippewa Falls. The meeting included a discussion with Rep. Michael Wilder of the State Assembly. Thomas Hadley, MD, was admitted to the society, transferring from the Dunn-Eau Claire-Pepin County Medical Society.

Fond du Lac. The Fond du Lac County Medical Society met on April 27, 1995. Dr Yuhas reviewed issues discussed at the SMS annual meeting.

Manitowoc. New members accepted into the Manitowoc County Medical Society include: Douglas E. Rapisarda, MD; Steven G. Umhoefer, MD; and Peter G. Van Oosten, MD.

Outagamie. The Outagamie County Medical Society approved membership for Scott D. Nygaard, MD; and Steven J. Turchan, MD.

Waukesha. William B. Burns, MD; and Henry M. Waldren, Jr, MD, have been approved for membership in the Waukesha County Medical Society.

Winnebago. The Winnebago County Medical Society met at Robbins Restaurant on May 4, 1995. Discussion included a legislative update on Gov. Thompson's state budget proposals, and the introduction of Jim Schleck, the new SMS field staff representative. Stephen Boyd Wilson, MD, was approved for membership. ❖

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training at the Medical College of Wisconsin Affiliated Hospitals, Inc., Columbia Hospital, Milwaukee.

John O. Simenstad, MD, PhD,* of Osceola, received a one-year fellowship in the field of medical education research from the Association for Surgical Education. Dr Simenstad is a staff physician at the Osceola Medical Center/Ramsey Clinic, where he has served since 1964. In addition to his practice in Osceola, he is also director of surgical education at the St. Paul Ramsey Medical Center.

Victor J. Sobolewski, III, MD,* recently became one of the first board-certified primary care sports medicine physicians in the United States. Dr Sobolewski of the Mercy Whitewater Medical Center and the Mercy Whitewater Sports Medicine and Rehabilitation Center was awarded the primary care sports medicine certification by a joint committee comprised of representatives from seven specialty certification boards within the osteopathic profession.

Nick W. Turkal, MD,* of Whitefish Bay, has been named to the 1995 White House Conference on Aging by Secretary of Health and Human Services Donna Shalala. Dr Turkal is an associate professor and associate chairman for the University of Wisconsin Medical School's Department of Family Medicine, Milwaukee Campus. He practices at St. Luke's Medical Center.

Michael Wilson, MD,* will staff the new Physicians Plus Medical Group clinic in Fitchburg. Dr Wilson is a board certified family practitioner who graduated from the University of Melbourne Medical School in Melbourne, Australia. He has practiced family medicine in Australia and most recently completed his US family practice residency.

Scott G. Zahn, MD,* has joined the Aurora Medical Group primary care clinic at the Aurora Health Center in the Town of Pewaukee. Dr Zahn is a graduate of the University of Minnesota Medical School in Minneapolis and is board certified by the American Board of Pediatrics. He served his pediatric internship and residency at the Medical College of Wisconsin.❖

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Division of Health to offer TB educational opportunity

The Wisconsin Division of Health TB Program is coordinating efforts to bring the satellite course: "Scientific basis of tuberculosis control" to interested health care personnel. This is a three-part broadcast from the National Tuberculosis Center in San Francisco developed for physicians and other medical professionals involved in the diagnosis, treatment and control of tuberculosis. There is no fee for attending and participants may register for all or part of the course. Category I CME credits will be available.

The course will be offered at six sites around the state including: Milwaukee (VA Hospital), Madison (VA Hospital), Superior (VA Hospital), Eau Claire, Wausau, and Green Bay. Space is limited so advance registration is necessary. To register to attend one of these sites, call the Wisconsin Tuberculosis Program, at (608) 261-6319. Include your name, mailing address, telephone number and site preference. The course will be broadcast over the IISTN network, check with your hospital to see if the program will be available locally.

June 29--Part 1--Current status of new diagnostic tests--Thomas Shinnick, Ph.D., Atlanta, Ga.,; Current status of new anti-tuberculosis agents--Michael D. Iseman, M.D., Denver, Colo.; and Genetic basis for and detection of drug resistance--Beate Heym, M.D., Paris, France; **July 6**--Part II--Hazardous environments and environmental controls--Edward A. Nardell, M.D., Cambridge, Mass.; Personal respiratory protection--Kevin P. Fennelly, M.D., M.P.H., Denver, Colo.; Institutional infection control: intervention and effectiveness--Samuel Dooley, M.D., Atlanta, Ga.; and **July 13**--Part III--Preventing and managing multidrug resistance--Paula Fujiwara, M.D., New York, N.Y.; and Behavioral aspects of treatment--Ester M. Sumartojo, Ph.D., Atlanta, Ga.❖

AMA awards

The Wisconsin physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by the commitment to continuing education, and the SMS offers them its congratulations. The * indicates members of the SMS.

Agoncillo, Jose R.
* Bartos, Craig L.
* Beaumont, Robert J.
* Costakos, Dennis T.
De Boe, Frederick M.
* Edland, Robert W.
* Grajewski, Michael A.
* Johnstone, Michael F.
Kronzer, William W.
* Larson, David Lee
* Lewis, James M.
* Lochen, Gregory R.
* Mc Donald, Mary F.
* Mc Mahon, Richard F.
* Memmen, James E.
* Miller, John J.
Moede, James G.
* Nogler, Calvin D.
* O'Reilly, Tedmond R.
* Penton, Lutti
* Peterson, Robert L.
* Rankin, James J.
* Ross, Arthur J.
Sanfelippo, Michael
* Sanger, James R.
* Semler, William L.
* Shaffer, Katherine A.
Singh, Sanjay
* Sorensen, Charles C.
* Starr, Robert A.
Stewart, Richard D.
* Suarez, Luis A.❖

Classified ads

INTERNAL MEDICINE - Prominent group practice is seeking an eighth internist. Located at the southern tip of Wisconsin's Fox River Valley, this safe, metropolitan center of 40,000 is the fastest-growing city in the state. Community offers a high standard of living without the high costs. Schools are among the best in the nation. Full range of diagnostic, medical, and surgical facilities provided by 161-bed hospital. Call Barbara Lakoski at 1-800-243-4353. 6/95

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STOUGHTON, WISCONSIN. Dean Medical Center, a 350 physician multispecialty group, is actively recruiting a BE/BC family physician for our Stoughton Clinic, which is located approximately 20 miles south of Madison (population 190,000). Currently there are 3 internists, 4 family practice physicians, 1 pediatrician and 1 general surgeon at this clinic. Call would be shared equally among the family physicians. The Stoughton Hospital is a 50 bed facility adjoining the new medical office building. Stoughton has a population of approximately 9,000 and growing with excellent schools and neighborhoods. This is an excellent position which enables you to live in a safe community with the cultural and professional resources of a larger city just minutes away. A two year guaranteed salary plus incentive and benefits is being offered for this position. Contact Scott Lindblom, Dean Medical Center, 1808 West Beltline Highway, Madison, Wisconsin, 1-800-279-9966, (608) 250-1550 (work), (608) 833-7985 (home) or FAX (608) 250-1441. 5-7/95

PEDIATRICIAN - B/C, B/E to join Pediatric Associates in Milwaukee, St. Joseph Hospital-Sherman Park community. Competitive salary, generous fringe benefits. Reply to Malke, c/o Pediatric Associates, 4267 W. Fond du Lac Ave., Milwaukee, WI 53216. 4-6/95

JANESVILLE, WISCONSIN. Dean Medical Center, a 300 physician multispecialty group, is actively recruiting additional BE/BC family physicians to practice at the Riverview Clinic locations in Janesville, Milton and Delavan, Wisconsin. Traditional family practice and urgent care opportunities are available. Janesville, population 55,000, is a beautiful, family oriented community with excellent schools and abundant recreational activities. Excellent compensation and benefits are provided with employment leading to shareholder status. Send CV to Stan Gruhn, MD, Riverview Clinic, PO Box 551, Janesville, WI 53547 or call (608)755-3500. An Equal Opportunity Employer. 4-6/95

MADISON, WISCONSIN. Dean Medical Center, a 300 physician multi-specialty group, is seeking additional family physicians to join its 30 member department. Positions are located at our Arcand Park, East Madison and Deerfield Clinic locations. All positions have an excellent call schedule and obstetrics is optional. Madison is the home of the University of Wisconsin with enrollment of over 40,000 students and the state capital. Abundant cultural and recreational opportunities are available year round. Excellent compensation and benefits are provided with employment

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JANESVILLE, WISCONSIN - URGENT CARE. Riverview Clinic, a division of Dean Medical Center, is actively recruiting an urgent care physician to join its medical staff. We recently increased our compensation package which is based on a 40 hour work week. Total compensation for Year 1 - $108,000.00, Year 2 - $134,642.00 and Year 3 - $135,000.00. We currently have two physicians which staff the clinic from 9:00 am - 9:00 p.m. Monday through Friday and 9:00 am - 11:30 am on Saturday and desire to expand the hours of operation until 9:00 pm on Saturday and 1:00 pm - 9:00 pm on Sunday. Our facility is brand new and well equipped with 8 exam rooms, lab and x-ray. Flexible hours are available with an expected total of 30-40 hours per week. Excellent compensation and benefits are provided. For more information contact Scott M. Lindblom, Dean Medical Center, 1808 West Beltline Highway, Madison, WI 53713, (work phone) 1-800-279-9966 or (608) 259-5151, Fax (608) 259-5294, (home phone) (608) 833-7985. 4-6/95

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WISCONSIN. BE/BC FP physician needed in clinic-based Urgent Care Center - part of a 35-physician multi-specialty group in west-central Wisconsin. Practice full time with some evenings and weekend hours; no call. Beautiful city of 60,000 in west central Wisconsin, 90 miles from Minneapolis/St. Paul. Competitive salary and excellent fringe package. Contact James Volk, MD Medical Director, Group Health Cooperative, PO Box 3217, Eau Claire, WI 54702-3217. (800) 218-1745. 4-7/95

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ISSUES IN PRIMARY CARE CONFERENCE. Friday, September 15 - Saturday, September 16, 1995. Landmark Resort and Conference Center, Egg Harbor, Wisconsin (Door County). Contact: Marshfield Clinic, Office of Medical Education, 1000 North Oak Avenue, Marshfield, WI 54449. 1-800-541-2895.

5-6/95

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, clinics, specialty societies, and medical schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 70 cents per word, with a minimum charge of $30.00 per listing. *All listings must be prepaid.*

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COPY DEADLINE for listings is 1st of the month preceding the month of publication: eg, copy for the August issue is due by July 1. Address communications to: *Wisconsin Medical Journal*, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free 1-800-362-9080.

OTHER MEETINGS in the United States are published in the first issue of each month of the *Journal of the American Medical Association.*

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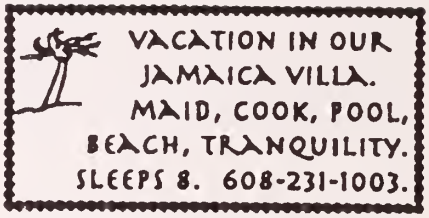

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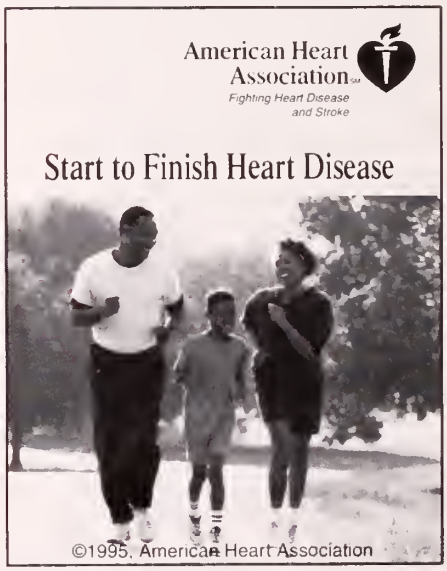

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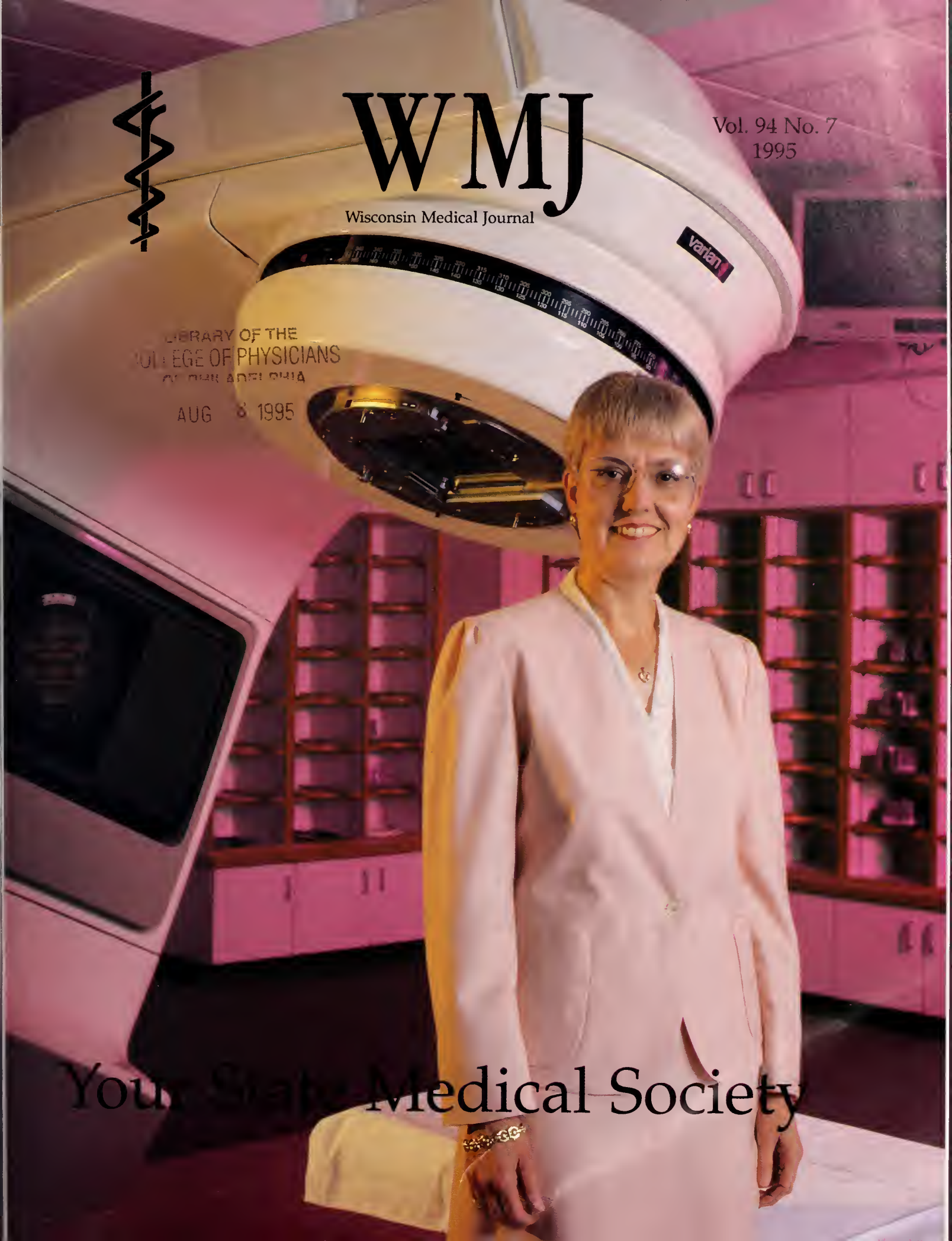

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Wisconsin Medical Journal

The *Wisconsin Medical Journal* (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor and editor are responsible for overseeing the production, business operation and contents of the journal. The editorial board, chaired by the medical editor, solicits and screens all scientific, special and soundings articles; it does not screen socioeconomic or organizational articles. The chair provides leadership for the editorial associates and comments on both editorials and letters to the editor. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *WMJ* nor the SMS take responsibility. The *WMJ* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

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State Medical Society of Wisconsin

Created by the Territorial Legislature in 1841 and now representing nearly 8,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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435 Classified ads

Our cover: SMS President Marcia J. S. Richards, MD, spends most of her time treating cancer patients in this or another linear accelerator room at St. Luke's Medical Center in Milwaukee. Dr Richards is focusing her term as president on helping physicians become better patient advocates and empower their patients to make fully informed choices about their care. See page 329. (Photo by Steve Ryan)

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President's page

Doctor, you're needed away from the bedside

ONCE WHEN I PICKED UP my patient's order sheet from my post at his or her bedside, I had only to consider how a test or treatment would impact that individual's health. If the risk/benefit ratio was positive, my pen was poised to write.

These days, however, I find myself taking the cap off my pen more slowly, as I reflect on treatment standards, cost/benefit ratios and HMO guidelines, among other directives. This bloom of "protocols" has served to make my decision process more complex and lengthy. But, fortunately, only rarely have any of these new postures directly conflicted with my clinical judgment.

As we zoom down this particular stretch of health care's highway, the growth of guidelines and mandates dot the skyline like miniature billboards. I fear that as support for these directives becomes more prevalent among the financial gurus of managed care, my decisions as an oncologist will face increased challenges by managed care organizations.

We have come to a juncture where increasingly, the needs of individuals are colliding with the needs of other health plan enrollees. Conflict may also occur based on concerns about the financial wellbeing of the managed care organization, or even the financial health of its providers, including physicians.

Still in the midst of all this construction and consternation, my primary responsibility as a physician has not changed. It remains my duty to recommend treatment to an individual patient if I believe that procedure will provide him or her with a significant health benefit.

Yet, as I realize this responsibility, I am increasingly aware of our larger patient - society as a whole, looking over my shoulder. It is society, this larger patient, which provides the resources to allow me to care for an individual patient. No longer can I provide care with financial blinders obscuring my vision. And since it is this larger patient, or its organizations (i.e. employers), who are paying the piper, I am not surprised at who I see starting to try and "pick the tunes."

The issue becomes: can we resolve fairly this potential conflict between the needs of an individual weighed against the resources and needs of society?

I believe we can develop positive solutions if we are proactive, prepared, and willing to participate. But we should not wait to get involved until we are standing at the bedside, grappling with challenges to our medical judgment.

We must, I believe, as practicing physicians, make it a priority now to become part of the policy-making panels for managed care organizations. We must be at the table, setting the standards for care, reviewing deviations from standards before treatment or reimbursement is denied, and participating in appeals on care decisions from patients or their physicians. We must be part of the inner circle or governance of the plans.

Marcia J. S. Richards, MD

To do so will require us to leave the bedside (or perhaps in this day of increasing outpatient care, we will need to come out of the exam room). We do little good for either our individual patient or our "larger patient" when our participation is lim-

Continued on next page

Continued from previous page
ited to joining the choir of the complaining.

If we fail to get actively involved in managed care plans in patient care policy development in a proactive way, or are denied involvement, the likely--and most unsatisfactory--result will be that we will be asked to do bedside or exam room rationing.

All our patients need our involvement--both the small ones and the large ones, not just at bedside but in the boardroom. Ask or, if need be, demand, to be involved.

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

Editorials are signed by the authors. These opinions are the authors' and do not necessarily reflect the policies of the SMS. Authorship of editorials is reserved for members of the *WMJ* editorial board, editorial associates and SMS elected officials.

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EVP report: The view from here
To boldly go where no one...

Each year after the annual meeting of the American Medical Association, I spend a couple of days with my family at a small town in Michigan called Grand Haven. My wife Diane's family has an old Victorian cottage there, Poplar Lodge, that sits high on a dune overlooking Lake Michigan. For 100 years the house has allowed six generations of her family to sit and stare across the lake toward Wisconsin.

On June 23, from this familiar vantage point, I find myself doing as the earlier generations have done, looking beyond the wash and wear of the tide to a distant point across the lake. My thoughts turn (as they so often do when I am in a quiet spot) to pondering where medicine has been and where it may go. It is the latter route that pulls my attention today.

After the tumult of the past few days in Chicago, watching physicians wrestle with a world which seemingly grows more complicated each day, the future of medicine has less clarity than the distant outlines across the water.

As a lone man on the dune, I am struck anew with the vastness of this inland ocean. I contemplate with awe the thought that men of generations past set out to traverse this and other immense bodies of water, launching forth in handhewn boats to bob up and down in the powerful waves. What courage that took!

Now it is our turn to be the visionaries, to chart the course. And let me tell you we have an excellent crew! As we launch our ship, Wisconsin is uniquely positioned to influence the views organized medicine will take in the congressional debate to restructure Medicare and Medicaid. At this session of the AMA House of Delegates, Kim Hetsko, MD, of Madison, one of your past presidents, was elected to the AMA Council on Medical Service, the body which formulates policy options on the socioeconomic issues that confront the profession. Dr Hetsko joins longtime SMS leader Ken Viste, Jr., MD, of Oshkosh

Thomas L. Adams, CAE

who serves on the Council on Legislation, which prioritizes AMA issues to be pushed in Congress. Another familiar face in Wisconsin medicine, Tim Flaherty, MD, of Neenah, is a sitting member of the AMA Board of Trustees, the board charged with taking the recommendations of the councils just mentioned, and meshing them together in a coherent program to influence Congress. These physicians are strong captains who have successfully weathered great storms and we are indeed fortunate to have benefit of their wisdom and experience.

In a "new wave" aka "interactive video" address at the AMA House, Speaker Newt Gingrich told the delegates that he and his colleagues want medicine's input as it reshapes federal health care programs now! (Whether you like or detest the speaker, he clearly is like FDR, a man with ideas and in a hurry.)

Medicine for now, unlike some other groups, has a seat at the table to reshape the system. Those who want Medicare, Medicaid, veterans' health or graduate education as we now know them will be left to quote one another "on the trash heap of history."

The rest of the country has much to learn from the Wisconsin experience. From programs such as PartnerCare, which recognized early on that different senior citizens have varying abilities to pay for care, to the willingness of the profession to try the HMO initiative in Medicare to our realization through Wisconsin Care that you cannot resolve the problems of the health care system without somehow having everyone in the system. We have been bold, and bold is what it will take to challenge the special interests of the status quo to reshape Medicare and Medicaid into mere responsive accountable programs that assure quality care.

Looking back across Lake Michigan, I know Wisconsin is there. I know its people are bright and industrious, its potential unlimited. So it is with medicine, its future is certain, it can be limited only by fear and lack of creativity.

Let's hope Doctors Hetsko, Viste, Flaherty, and their colleagues have the courage to cast off the tired old programs and reshape, with the Congress, a new era that can be the beginning of a new age of innovation in the delivery of our nation's health care. ❖

Letter
Influence of medical economics

To the editor: I am worried about the growing influence of medical economics upon our profession. In particular, I am uneasy that in some way my diagnosis and treatment decisions can be motivated by cost containment concerns rather than patient care. Will I elect to not perform a test or procedure because it is medically unnecessary, or because it would benefit my expense profile within my physician group or HMO? Is the term "defensive medicine" being broadened from its original medicolegal context to define decision making that "covers your butt" economically?

Equally as disturbing, however, because they apply on a wider scale, are the ethical conflicts inherent in making policy within organized medicine. Our SMS members, under the pressure of managed care and the growing complexity of the business of medicine, are forming even larger and more competitive physician groups. In some areas of the state, these entities are truly dominating their health care markets. Leaders of such groups are obviously chosen, in part, for their ability to further the economic health of the collective. I am uncomfortable, therefore, about policy being made at our SMS Board of Directors by physicians who occupy leadership roles in economic entities that could benefit by this policy at the expense of other society members.

I know that I can ease my personal economic conflicts surrounding "bedside rationing" of patient care by striving to base my decisions on well defined and widely accepted guidelines of equality. How successful I can be with this remains to be seen. Our SMS should, as well, adopt more stringent ethical safeguards. All society officers, directors and commission chairmen should, during their term of service, relinquish control of financial interest in any economic entity that could directly benefit in the marketplace from SMS board policy. Furthermore, they should also refrain from providing directive, managerial, advisory or consulting services to such entities. I also believe that prospective leaders of our society should submit personal financial statements before an independent ethics authority prior to assuming office to avoid any appearance of fiscal impropriety. These measures

Continued on next page

Continued from preceding page
would strengthen the Society's 18 year policy statement on conflict of interest within today's increasingly competitive health care climate, and protect those who seek to lead an organization in a truly impartial manner. We would ask no less of ourselves.

--James D. Buck, MD
Milwaukee❖

Editorial
Whither WMJ.....

"If we were to start all over again to design a model for modern medicine, most of us would opt for a design which concerns itself far, far more with the preservation of health, of well being. What we have instead is the very opposite: a system of medicine which reacts, which responds, which waits to pick up broken pieces - a form of medicine in short, concerned with illness, not health." Ian Kennedy 1994

If we were to start all over again to design a journal to meet the needs and interests of 8000 plus members of the State Medical Society of Wisconsin caught in an era of escalating change, surrounded by a plethora of specialty journals (keepers and throw-aways), mountains of paperwork drudgery, and countless regulations, directives and memos, some of which are important, some not, I am sure that relatively few of us would settle on the design of the *Wisconsin Medical Journal* as it now stands.

The question, of course, is what can and should be done to the *Journal* such that its arrival on each of our desks will prompt a "Hah, let me see what its got in it this month" thought, rather than "Another one so soon - I haven't even scanned the last one (or two, or three)." Perhaps that is why the powers that be (PTB) chose to invite me to become the medical editor following Bud Sautter's long and distinguished service, for which we salute him. JD Kabler was to take the position. We are all the poorer for being deprived of the joy of witnessing the power of JD's intellect. Perhaps the PTB decided to try someone who likes to change things, who tries to listen and doesn't seem to mind when his ideas flop! Anyhow, the appointment as medical editor is an annual one - "he can't mess things up too much in a year" is a thought that may have run through the minds of the PTB. Whatever the motivation, I am honored and flattered to be designated as medical editor and perhaps we, namely you, the PTB, the Editorial Board, and the staff can work together to produce a publication which allows for important multidirectional communication, which carries information of crucial importance to Wisconsin physicians and from Wisconsin physicians to the PTB (and maybe lots of other people, too) and which provides some entertainment, even it if appeals to only those with a weak sense of humor.

So, what am I suggesting? Maybe a couple of things. What about

1) a series on "the best management of ..... a 62 year old executive with early signs of Parkinsonism or ..... a 52 year old physician with active RA, or ..... a 12 year old with sudden onset of dyspnea and chest pain"?
2) Notes from a recent conference on ... say Alzheimers Disease that many of us would like to have attended but none of us could spare the two days of sitting through the conference.
3) Recasting the Ethics in Everyday Practice series into a format such that we can read the ethicists views on the vignette, but can also submit our own views.

Thomas C. Meyer, MD

What do you think? I would be grateful to receive your ideas on "If I were to re-design the *WMJ*, I would ....." Please be brief, legible, but forthright.

I must tell you that we are initiating a "Delphi probe" which is a mechanism to obtain ideas and judgements from widely dispersed and busy people on their thoughts on the future of the *WMJ*. I would love to be able to include your ideas. *WMJ* is your journal, tell us how we can make it really interesting, worthwhile and fun for you.

--Thomas C. Meyer, MD
Madison❖

SMS officers and directors: 1995-1996

Marcia J.S. Richards, MD
Milwaukee
President
(1995-1996)

A board-certified radiation oncologist, Dr Richards is in private practice in Milwaukee where she is medical director of the section of radiation oncology at St Lukes Medical Center. She is also president of Radiation Oncology Associates, SC, a 12-person radiation oncology group with three practice bases—Milwaukee, Green Bay and Racine-Kenosha.

Dr Richards began her college education as an applied horn major at Eastman School of Music, later taking two years of pre-medicine work. She graduated from the University of Wisconsin Medical School in 1970, completed an internship in pediatrics at University of Wisconsin Hospitals-Madison, and then did a fellowship in radiation oncology at the same institution. Board-certified in radiology (therapeutic) in 1974, she was an assistant professor for three years at the University of Wisconsin-Madison in human oncology and radiology. In 1977 she went into private practice in Milwaukee at St Marys Hospital, moving to St Lukes in 1984.

Dr Richards has served on the SMS Board of Directors since 1988. She was president of the Medical Society of Milwaukee County in 1990-1991 and has served as an MSMC board member since 1986. She has served on the board of directors for the Foundation for Medical Care Evaluation (1982); American Cancer Society Wisconsin Division, serving as ACS president in 1993-1994; and the Wisconsin Radiological Society (1989-present), where she currently serves as vice president. She is also past president of the Wisconsin Society of Radiation Oncologists (1981-1983) and current board member for PIC Wisconsin.

The new SMS president has been an advocate for education of women on the subject of breast cancer, serving as chair of the Breast Cancer Detection and Awareness Project and speaking to local, state and national organizations on breast cancer.

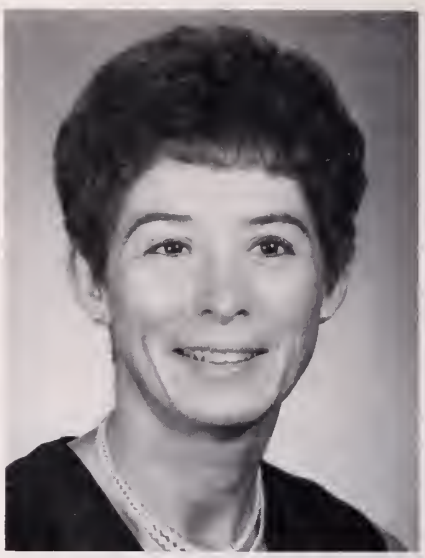
Marcia J. S. Richards, MD

Richard H. Ulmer, MD

Thomas L. Adams, CAE

Harry J. Zemel, MD

Richard G. Roberts, MD, JD



Sandra L. Osborn, MD

Michael C. Reineck, MD

Raymond C. Zastrow, MD

Mark H. Andrew, MD

Richard H. Ulmer, MD
Marshfield
President-Elect
(1995-1996)

Dr Ulmer received his MD and MS in physiology from Stritch School of Medicine of Loyola University, Chicago, He served his internship and residency in cardiology at the University of Chicago Hospital and Clinics. He is a cardiologist at the Marshfield Clinic. Dr Ulmer was president of the Wood County Medical Society in 1978 and 1985. He chaired the SMS Board of Directors from 1989-1994, and is a member of the SMS Steering Committee, AMA Forum of Employed Physicians, and SMS Committee for Young Physicians. He has been a member of the AMA Advisory Committee on Group Practice Physicians since 1992, and was an alternate delegate to the AMA for the past ten years, becoming a delegate in 1995.

Thomas L. Adams, CAE
Madison
Executive Vice President
(1995-1996)

Thomas L. Adams was named secretary-general manager of the SMS in 1987. Adams was director of the Washington, DC, office of the American Society of Anesthesiologists prior to joining the Society in 1986 as secretary-general manager designate. Adams served as assistant executive director and lead lobbyist for the North Carolina Medical Society from 1978 to 1983, when he joined the anesthesiology group. Adams graduated from Lenoir Rhyne College in Hickory, NC.

Harry J. Zemel, MD
Fond du Lac
Treasurer
Director, District 5
(1995-1997)

Dr Zemel was first elected to the Board in 1987. He graduated from the University of Missouri School of

Continued on page 336

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Continued from page 334
Medicine and specializes in pathology. Dr Zemel was president of the Fond du Lac County Medical Society in 1979, chair of the SMS Finance Committee since 1989, and has been SMS Treasurer since 1993. Currently Dr Zemel serves on the Finance and Investment Committees for the College of American Pathologists.

Richard G. Roberts, MD, JD
Madison
Immediate Past President
(1995-1996)

A board-certified family physician, Dr Roberts is a professor in the Department of Family Medicine at the University of Wisconsin Medical School and practices family medicine in Belleville. He is on the medical staff of St Mary's Hospital Medical Center, University of Wisconsin Hospitals and Meriter Hospital, all in Madison. Dr Roberts graduated from George Washington University Medical School in Washington, DC, in 1980.

Dr Roberts has served on the board of directors for the medical society since 1987. He was first elected as speaker of the SMS House of Delegates in 1987 and served through 1993. He is vice speaker of the American Academy of Family Physicians and has served on numerous AAFP committees. Dr Roberts is a past president of the Wisconsin Academy of Family Physicians. He is a director for the Wisconsin Institute of Family Medicine, HMO of Wisconsin Insurance Company and Physicians Insurance Company of Wisconsin; is a past member of the joint Commission on the Accreditation of Health Care Organizations task force on obstetrics; and currently serves on the Health Care Quality Improvement Initiative Steering Committee for the Wisconsin Peer Review Organization.

Dr Roberts serves on the Legisla-

Clarence P. Chou, MD

Timothy G. McAvoy, MD

Marvin G. Parker, MD

John E. Ridley, III, MD

Jay F. Schamberg, MD

George R. Schneider, MD

Frank H. Urban, MD

Robert F. Purtell, Jr., MD

Cassandra P. Welch, MD

Andrew B. Crummy, Jr., MD

Cyril M. (Kim) Hetsko, MD

Jerry M. Ingalls, MD

tive Special Council on School Health Services and the Governor's Task Force on Medical Center Costs. Nationally, Dr Roberts is a member of the Prostate Health Council and the Medical Advisory Panel of the Blue Cross and Blue Shield Technology Evaluation Board.

Sandra L. Osborn, MD
Madison
Speaker, House of Delegates
(1995-1997)

Dr Osborn, whose specialty is pediatrics, graduated from the University of Wisconsin Medical School in Madison. She was a member of the SMS Board of Directors representing District 2 from 1987 to 1993. She is a member of the WISPAC Board of Directors and co-chair of the SMS/WNA Committee. Dr Osborn served as president of the Dane County Medical Society from 1982 to 1983. She has also served as chair of the House of Delegates Nominating Committee, the Credentials Committee and the Reference Committee on Scientific Affairs. Dr Osborn also served on the Ad Hoc Committee on Child Abuse and Neglect and the SMS Committee on Women Physicians.

Michael C. Reineck, MD
West Bend
Vice speaker, House of Delegates
(1994-1996)

Dr Reineck graduated from the University of Wisconsin in 1970 and completed an internship at Milwaukee County General Hospital and a residency at St Mary's Hospital, in affiliation with the Medical School of the University of Michigan, in Grand Rapids. He has been in private practice at Orthopaedic Associates of West Bend, SC. Dr Reineck is past chair of the Governmental Affairs Commission, and past presi-

dent of the Wisconsin Orthopaedic Society and the Washington County Medical Society. He is also a past member of the Wisconsin Professional Liability Committee. He is a member of the American Academy of Orthopaedic Surgeons ICD-9-CM Coding Committee, Health Care and Financing Committee, and Bylaws Committee. He was the Washington County Medical Society delegate to the SMS House of Delegates for 11 years prior to his election as vice speaker.

Raymond C Zastrow, MD
Milwaukee
Chair, Board of Directors
Director, District 1
(1995-1998)

Dr Zastrow, who specialized in clinical pathology, graduated from Marquette University School of Medicine (now the Medical College of Wisconsin). He served on the SMS Physicians Alliance Commission from 1977 to 1989, and was a member of the WISPAC Board of Directors. He served as chair of the SMS Bylaws Committee, a member of the Finance Committee and was an alternate delegate to the AMA from 1983 to 1984. Dr Zastrow has also served on the AMA ad hoc committee on the Health Policy Agenda for the American People (HPA). He has served on the Board of Directors since 1987, and had been vice-chair since 1989.

Mark H. Andrew, MD
Viroqua
Vice chair, Board of Directors
Director, District 3
(1995-1998)

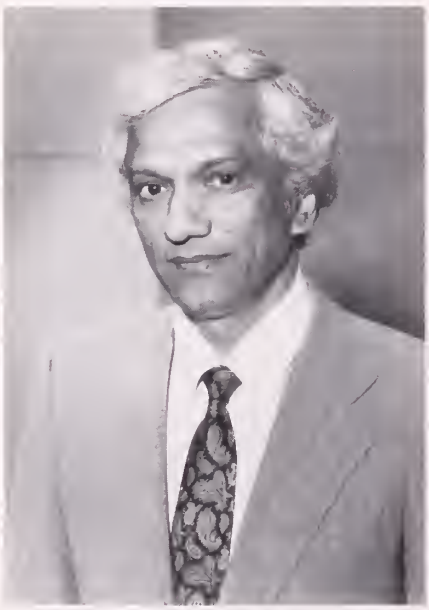
Dr Andrew, a general surgeon, graduated from the University of Wisconsin Medical School, and served his internship and residency at Southwestern Michigan Area Health Education Center in Kalamazoo. He was chair of the SMS Young Physicians Section in 1991. He also is a member of the SMS Commission on Governmental Affairs, the SMS Ad Hoc Membership Committee, the SMS Nominating Committee, and is the current president of the Vernon County Medical Society.

Clarence P. Chou, MD
Mequon
Director, District 1
(1994-1996)

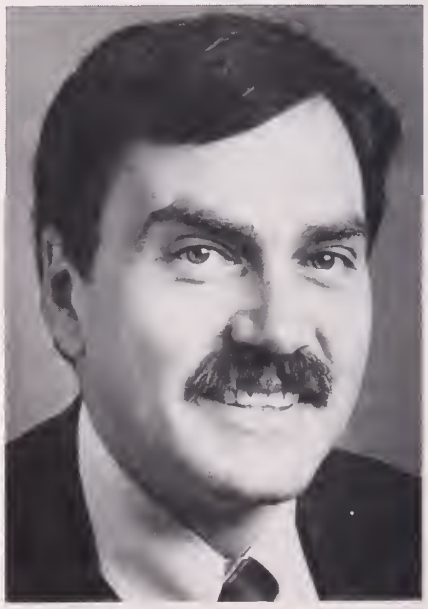
Dr Chou received his medical degree from the Medical College of Wisconsin. He completed his internship, residency, and a fellowship in child psychiatry at Medical College of Wisconsin Affiliated Hospitals. He practices at the Child-Adolescent Treatment Center in Wauwatosa. He serves as a consultant to Southeastern Wisconsin Medical and Social Services, Inc., and is the consulting psychiatrist at Marquette University. Dr Chou is an assistant clinical professor at the Medical College of Wisconsin, and an examiner for the Child Psychiatry Boards. He is chair of the Public Education Committee of the Medical Society of Milwaukee County, as well as a member of the Task Force on Managed Care and the Strategic Planning Committee. He is a member of the SMS Commission on Public Information, and a member of the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, and the Wisconsin Psychiatric Association.

Timothy G. McAvoy, MD
Waukesha
Director, District 1
(1993-1996)

Dr McAvoy graduated from New York Medical College. Specializing in internal medicine and emergency medicine, Dr McAvoy served his internship at Boston City Hospital. His residency was completed at Boston


Ayaz M. Samadani, MD

Paul A. Wertsch, MD


Bradley L. Manning, MD

Jack M. Lockhart, MD

Robert J. Jaeger, MD

James R. Keuer, MD

City Hospital and the University of Wisconsin Hospital and Clinics in Madison. He served as president of the Waukesha County Medical Society and has been a member of the Governmental Affairs Commission since 1987.

Marvin G. Parker, MD
Racine
Director, District 1
(1993-1996)

A hematologist, Dr Parker received his medical degree from the University of Missouri in St Louis, and served his residency and fellowship in internal medicine and hematology at the University of Missouri. Dr Parker began practice in Racine in 1966. In 1986, he joined SC Johnson Wax as corporate director of occupational and preventive medicine and in 1990, became vice president of Corporate Medical Affairs. He chaired the SMS Health Planning Commission for five years and also chaired the SMS Task Force on Medical Manpower.

John E. Ridley, III, MD
Milwaukee
Director, District 1
(1993-1996)

Dr Ridley, an ophthalmologist, graduated from the University of Indiana School of Medicine. His residency was completed at the Marquette School of Medicine. He is currently the assistant clinical instructor in ophthalmology at the Medical College of Wisconsin. Dr Ridley served as a captain in the US Air Force from 1961 to 1963. He is a member of the Milwaukee Ophthalmology Society and the American Academy of Ophthalmology. He is on the Board of Directors at Saint Mary's Hospital Milwaukee, vice-president of Prevent Blindness-Wisconsin, a member of the Board of Directors of Prevent Blindness-America, and a member of the Badger Association of the Blind Advisory Board.

Jay F. Schamberg, MD
Waukesha
Director, District 1
(1993-1996)

A pathologist, Dr Schamberg received his medical degree from Hahneman Medical College and served his internship at Chestnut Hill Hospital in Philadelphia. Dr Schamberg completed his residency at the Peter Bent Brigham Hospital in Boston and the University of Vermont Hospital in Burlington. He serves on the medical staffs of Community Memorial Hospital, West Allis Memorial Hospital, and Columbia Hospital. Dr Schamberg is past-president of the Wisconsin Society of Pathologists and a past president of the Waukesha County Medical Society.

George R. Schneider, MD
West Allis
Director, District 1
(1994-1997)

A specialist in internal medicine, Dr Schneider graduated from Marquette University School of Medicine (now the Medical College of Wisconsin) in Milwaukee and served an internship at the University of Missouri Medical Center in Columbia. He also completed a residency at the Medical College. Dr Schneider is a member of the American Society of Internal Medicine and the American College of Physicians.

Frank H. Urban, MD
Brookfield
Director, District 1
(1994-1997)

Dr Urban is a retired physician and is currently the State Representative for the 99th Assembly District. He received his medical degree from the UW-Madison, and an MS from the University of Minnesota. Dr Urban is the past president of the Milwaukee County Medical Society, an as-

Robert E. Phillips, MD

Terry L. Hankey, MD

Kevin F. Quinn, MD

sistant clinical professor at the Medical College of Wisconsin, and is a member and past president of the Wisconsin Dermatology Society. Legislative appointments include vice chair of the Assembly Committee on Health, chair of the Subcommittee on Nursing Homes, chair of Urban and Local Affairs, and a member of Consumer Affairs and Urban Education.

Robert F. Purtell, Jr, MD
Milwaukee
Director, District 1
(1995-1998)

Dr Purtell has been a member of the SMS Board of Directors and its Executive Committee since 1989. He was chair of the SMS Federal Legislative Policy Committee from 1977-1985, and a member of the Commission on Governmental Affairs from 1978-1985. He served as the delegate to the House of Delegates, Family Practice Section, and chair of the Physicians Alliance Commission from 1985 through 1989. Dr Purtell served on the Reference Committee on National Issues at the House of Delegates in 1980-1982. He was a member of the Nominating Committee from 1986-1990. Dr Purtell has been active in the Wisconsin Academy of Family Physicians. He served as president of the Milwaukee County Medical Society in 1992-1993, and has been an alternate delegate to the AMA since 1990. He was president and chair of the board of directors of PrimeCare Health Plan of Wisconsin from 1982 through 1986. Dr Purtell graduated from Marquette University in 1961, and served his internship at Misericordia Hospital, in Milwaukee, and his residency at St Joseph's Hospital, in Milwaukee.

Cassandra P. Welch, MD
Milwaukee
Director, District 1
(1995-1998)

Dr Welch, is an internist and the medical director of Milwaukee Health Services, Inc., who graduated from the Medical College of Wisconsin and completed her residency at Long Beach Veterans Administration Medical Center in Long Beach, Calif. She is a member of the Medical Society of Milwaukee County's (MSMC) Professional Education Committee, where she serves as vice chair. Previously, she was a member of the MSMC Ethics Committee. In addition to MSMC, she is presently serving on the State Program Advisory Committee for Wisconsin Area Health Education Center; the Milwaukee Area Health Education Center as Board vice president; the Governor's Council on African American Affairs and Region V Clinician's Network, as president.

Andrew B. Crummy, Jr, MD
Madison
Director, District 2
(1993-1996)

Dr Crummy is a professor of radiology at the University of Wisconsin Hospital and Clinics. A native of New Jersey, Dr Crummy graduated from Boston University Medical School and served his residency at University Hospital and Clinics in Madison. He was a member of the editorial board for the *Wisconsin Medical Journal* from 1985 to 1994.

Cyril M. (Kim) Hetsko, MD
Madison
Director, District 2
(1994-1997)

Dr Hetsko was president of the SMS from 1991-1992. He graduated from the University of Rochester School of Medicine and Dentistry and completed his internship and residency and was chief resident at the University of Wisconsin Hospitals. He has been a member of the Dean Medical Center since 1975 and is clinical professor of medicine at the University of Wisconsin, Madison.

Dr Hetsko was president of the Wisconsin Society of Internal Medicine from 1987 to 1988. He has been chair of the SMS Task Force on AIDS since 1987. In addition, his SMS activities have included: vice speaker of the House of Delegates, a member of the Task Force on RBRVS, Strategic Planning Committee, and Task Force on Physician Discipline and Review; and service on the Board of Directors from 1978-1987 and from 1993 to present, and past chair of the board finance committee.

He has been a member of the Wisconsin delegation to the AMA since 1983, and is currently chair of the delegation. Dr Hetsko was recently elected to the AMA Council on Medical Service. He is a past chair of the Department of Medicine at St Mary's Hospital Medical Center, Madison.

He has received the Presidential Award from the Dane County Medical Society and the SMS Meritorious Service Award. Dr Hetsko is now a trustee of the American Society of Internal Medicine, and is a member of the Commission on Office Laboratory Accreditation.

Jerry M. Ingalls, MD
Monroe
Director, District 2
(1994-1997)

Dr Ingalls is the president of the Board of Directors of the Monroe Foundation. He graduated from Duke University, Durham, North Carolina, and completed his internship and residency at Duke University and the University of Oklahoma. A past president of the Illinois State Medical Society (1975), he presently serves as chair of the Medical Quality Research Council.

Ayaz M. Samadani, MD
Beaver Dam
Director, District 2
(1994-1997)

A family physician, Dr Samadani received his medical degree in Pakistan. He served his internship at Henrotin Hospitals in Chicago. He spent 5 years of post graduate training in internal medicine and pediatrics in London. He is a fellow of the Royal Society of Tropical Medicine and Hygiene and certified in child health from the Royal College of Physicians and Surgeons of London. He has been in practice in Beaver Dam since 1971, and is chair of the pediatric department of Beaver Dam Community Hospital. He has served as secretary and president of Dodge County Medical Society and is past president of the Wisconsin chapter of the Association of Pakistani Physicians of North America. Dr Samadani is a member of the AMA Advisory Committee of International Medical Graduates, and a fellow of the American Academy of Family Physicians.

Paul A. Wertsch, MD
Madison
Director, District 2
(1994-1997)

Dr Wertsch graduated from the University of Wisconsin Medical School in 1970. He completed a rotating internship at St Paul Ramsey Hospital and a family practice residency at USPHS Indian Hospital in Gallup, NM. He was a co-founder of the Wildwood Family Clinic, where he has been practicing since 1978. Dr Wertsch was chair of the Department of Family Practice, St Mary's

David J. Deubler, MD

Stephen D. Hathway, MD

Anthony R. Mars, MD

Charles V. Ihle, MD

Douglas M. De Long, MD

Robert L. Sellers, MD

Hospital Medical Center, from 1983-1986, and chief of staff at St Mary's from 1988-1990. He was an alternate delegate to the SMS from 1986-1989, and a delegate from 1989 to the present. Committee experience includes credentials, pharmacy and therapeutics, utilization, bio-ethics, integrated quality assurance, bylaws, medical records, and executive.

Bradley L. Manning, MD
Madison
Director, District 2
(1995-1998)

Dr Manning, whose specialty is plastic and reconstructive surgery, graduated from the University of Illinois College of Medicine and completed his general surgery and plastic surgery residency at the University of Wisconsin-Madison. He has served as a trustee and president of the Dane County Medical Society. He was chair of the Department of Surgery and Vice-President of medical staff at Meriter Hospital. Dr Manning served on the SMS Task Force on Health Care Reform and on the Commission on Public Information. He has served as a delegate for the SMS and is currently a director and member of the Health Care Financing and Delivery Commission.

Jack M. Lockhart, MD
La Crosse
Director, District 3
(1995-1998)

A specialist in rheumatology, Dr Lockhart graduated from Harvard Medical School and served an internship at University Hospitals of Cleveland. He also completed fellowships at the University of Minnesota Medical School in Minneapolis. Dr Lockhart has served as a delegate to the SMS and as a member of the Nominating Committee. He also served on the SMS Physicians Alliance Commission for 9 years and is a member of the SMS Finance Committee and the Executive Committee of the La Crosse County Medical Society. He is also a past president of the La Crosse County Medical Society.

Robert J. Jaeger, MD
Stevens Point
Director, District 4
(1994-1997)

Dr Jaeger is a specialist in obstetrics and gynecology. He attended the University of Wisconsin Medical School and served an internship and residency at Milwaukee County General Hospital. Dr Jaeger is an assistant clinical professor in the Department of Obstetrics and Gynecology at the Medical College of Wisconsin and serves on the board of directors of the University of Wisconsin Medical Alumni Association. He has served on the SMS Board of Directors since 1988, and is currently a member of the SMS Commission on Maternal and Child Health and the Maternal Mortality Committee. Dr Jaeger is a member of the board of directors for the Portage County Medical Society as well as an alternate delegate. He is president of the Wisconsin Society of OB/GYN and also chair of the Wisconsin Section of the American College of Obstetrics and Gynecology. Dr Jaeger became an alternate delegate to the AMA in 1995.

James R. Keuer, MD
Minocqua
Director, District 4
(1995-1998)

Dr Keuer graduated from the Chicago Medical School in 1954. He completed his internship at Milwaukee County General Hospital, and his residency in general surgery at the Veterans Administration Center, Wood, Wisconsin. He served in the US Navy for two years prior to opening his practice in general surgery in Medford. He also practiced in Minocqua. Since 1993, he has been working in the Department of Ur-

gent Care at Marshfield Clinic, Lakeland Center in Minocqua.

Robert E. Phillips, MD
Marshfield
Director, District 4
(1995-1998)

Dr Phillips, a general internist and geriatrician, received his medical degree from Northwestern University Medical School in Chicago, and served his residency in Internal Medicine at the University of Minnesota Affiliate Hospitals. Dr Phillips has been in practice at the Marshfield Clinic since 1979. He has been a member of the SMS since 1979, and has served on the Commission on Mediation and Peer Review, Commission on Geriatric Health, and is currently a member of the Commission on Public Information. Dr Phillips was the ad hoc chair of the State Mini-Internship Committee and has been a delegate to the House of Delegates Annual Meeting from Wood County since 1988. He is also a past president of the Wood County Medical Society. Dr Phillips was a member of the nominating committee of the SMS from 1990-1995, serving as chair in 1992-1993. In addition, Dr Phillips was president of the Wisconsin Association of Medical Directors in 1989, and president of the Wisconsin Society of Internal Medicine in 1990. He also served on a Task Force for Health Care Reform of Wisconsin Care in 1993. Dr Phillips is a member of the American Society of Internal Medicine, American College of Physicians, American Medical Directors Association, American Geriatric Society, and American Medical Association.

Terry L. Hankey, MD
Waupaca
Director, District 5
(1993-1996)

Dr Hankey graduated from Wright State University and Duke University Medical College. He served his residency in family practice in Madison. He has been in practice in Waupaca for 20 years. For two years, he was residency director at the UW Family Practice Residency in Wausau. He is past president of the Wisconsin Academy of Family Physicians and an alternate delegate to the AAFP. He is a board member of the Wisconsin Institute of Family Medicine and chair of the AAFP Committee on Health Education. Dr Hankey was chair of the WAFP Task Force on Access to Care.

Harry J. Zemel, MD
Fond du Lac
Director, District 5
(1994-1997)

Dr Zemel was first elected to the Board in 1987. He graduated from the University of Missouri School of Medicine and specializes in pathology. Dr Zemel has been chair of the Finance Committee since 1989. He is also a member of the Ad Hoc Membership Committee and was president of the Fond du Lac County Medical Society in 1979.

Kevin F. Quinn, MD
Neenah
Director, District 5
(1995-1998)

Dr Quinn received his medical degree and served a surgical residency at the Medical College of Wisconsin. He was a visiting registrar at Oxford University, John Radcliffe Hospital, Neuffield Department of Surgery. He practiced at the Nicolet Clinic in Neenah from 1982-1989, and is presently in private practice in Neenah.

David J. Deubler, MD
Kiel
Director, District 6
(1994-1997)

Dr Deubler received his medical degree from the UW-Madison Medical School, and completed an internship and residency in family practice at UW Affiliated Hospitals-Wausau. A board certified family practitioner, he joined the Sheboygan Clinic in 1986 and presently practices in its satellite clinic in Kiel. He is a member of the American Academy of Family Practice and the Wisconsin Academy of Family Practice.

Stephen D. Hathway, MD
Green Bay
Director, District 6
(1995-1998)

A pathologist, Dr Hathway graduated from Indiana University School of Medicine in Indianapolis and completed an internship and residency at the South Bend Medical Foundation in South Bend, Ind. Dr Hathway is a member of the SMS Finance Committee. Dr Hathway was a member of the SMS Health Care Financing and Delivery Committee and served on the Committee on Alcoholism and Other Drug Abuse. He is also a past president and past secretary of the Brown County Medical Society.

Anthony R. Mars, MD
Marinette
Director, District 6
(1995-1998)

Dr Mars trained at the Mount Sinai Medical Center in New York City with residencies in internal medicine and anesthesiology. He has since been a resident of Wisconsin and a member of SMS. Locally, Dr Mars has served as medical staff president, liaison officer to the hospital board, and chaired the credentials and surgical committees. In 1992, he received the WISPAC chairman's award for "Outstanding Physician Participation."

Charles V. Ihle, MD
Eau Claire
Director, District 7
(1994-1997)

Dr Ihle graduated from the UW-Madison Medical School in 1965. He interned at St. Mary's Hospital in San Francisco, and completed his

residency in orthopedics at University Hospitals, Madison, He served in the US Navy from 1970-1973, as chief of orthopedics at the US Naval Hospital in Taipei, Taiwan. Dr Ihle has been practicing at the Ihle Orthopedic Clinic since July 1973. He is a member of the Commission on Health Care Financing and Delivery.

Douglas M. De Long, MD
Ladysmith
Director, District 7
(1995-1998)

Dr De Long graduated from the University of North Carolina at Chapel Hill School of Medicine in 1979. He served his residency and chief residency in Internal Medicine at Mary Imogene Bassett Hospital in Cooperstown, New York and is currently the president of the Bassett Alumni Association. He obtained added qualifications in geriatric medicine in 1985, and served a mini fellowship in geriatrics at UNC-CH in 1990. He is a member and fellow of the American College of Physicians. Dr De Long is presently a physician-director of the Marshfield Clinic at Ladysmith Center, having joined the group in 1983. He is also a member of the advisory board to the National Farm Medicine Center in Marshfield.

Robert L. Sellers, MD
Superior
Director, District 8
(1993-1996)

Dr Sellers graduated from the University of Illinois School of Medicine and is in family practice. He is a member of the SMS finance and executive committees. In addition, Dr Sellers is a past president of the Douglas County Medical Society.

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Occupational Medicine • Urgent Care
General/PV Surgery • Ob/Gyn

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WAUSAU MEDICAL CENTER
2727 Plaza Drive, Wausau, WI 54401

SMS commissions and task forces: 1995-1996

THE FOLLOWING IS A LIST of SMS commissions and task forces, and their members for 1995-96. The original year of each member's appointment, as well as the expiration of his or her term, at the annual meeting of the year designated appears with each member's name. Chairs of commissions are appointed for one-year terms by the Board of Directors. Vice chairs are elected at the first meeting of each commission following the annual meeting. This issue of the WMJ is prepared prior to most of these elections; therefore, some commissions will not include these designations.

Commissions

Addictive Diseases

This commission shall be concerned with the prevention, treatment, and rehabilitation for persons affected by addictive disorders, with an emphasis on alcohol and other types of drug abuse.

Michael G. Deeken, MD, Wauwatosa, 1990/1993-1996
Edward S. Friedrichs, MD, Brown Deer, 1995/1995-1996
Fred H. Koenecke, Jr, MD, Richland Center, 1990/1993-1996, chair
Michael M. Miller, MD, Madison, 1990/1993-1996
Sheila W. Sorkin, MD, Sheboygan, 1993/1993-1996
Barbara L. Calhoun, MD, Madison, 1994/1994-1997
John R. Gladieux, MD, Milwaukee, 1988/1994-1997
David R. Hendricks, MD, Madison, 1994/1994-1997
Brian E. Lochen, MD, Madison, 1991/1994-1997
Edward O. Lukasek, MD, Sparta, 1986/1994-1997
Scott D. Beede, MD, La Crosse, 1995/1995-1998
Randall J. Kieser, MD, Madison, 1992/1995-1998
George Locher, MD, Wausau, 1993/1995-1998
Thomas H. Peterson, MD, Wausau, 1989/1995-1998
Anne M. G. Schierl, MD, Stevens Point, 1989/1995-1998
Leonard W. Worman, MD, Milwaukee, 1993/1995-1998
Jeffrey Collins, medical student, UW
Jane Campbell, Neenah, Alliance
Irene Thearle, Neenah, Alliance

Staff support: Anne Bicha/Karen Baier

Continuing Medical Education

This commission shall consist of up to 20 appointed members and the deans of the two medical schools in Wisconsin, or their designees, with vote. It shall be responsible for all matters relating to the whole continuum of medical education, i.e., medical school and residency training as well as lifetime medical learning (continuing medical education). In addition, it shall be responsible for liaison with the medical schools in Wisconsin, their students, residents, fellows and departments of continuing medical education; liaison with specialty societies in the achievement of these goals; liaison with the Commission on Mediation and Peer Review and the Ad Hoc Committee on Health Planning for purposes of implementing continuing medical education programs related to responsibilities and activities of these two groups; and ongoing scientific programs of the State Medical Society. It shall be responsible for accreditation of continuing medical education in hospitals and other institutions or organizations within the state, but shall not be responsible for accreditation of continuing medical education within the state's medical schools.

John W. Beasley, MD, Madison, 1988/1993-1996
Richard P. Day, MD, Madison, 1993/1993-1996
Paul R. Glunz, MD, Hubertus, 1993/1993-1996

Continued on next page

The work of SMS task forces and commissions often continues outside the conference room as physicians weigh pros and cons of policy decisions and took out for their patients' best interests.

Continued from preceding page
James M. Lewis, MD, Baraboo, 1991/1993-1996
George Nemec, Jr, MD, Woodruff, 1987/1993-1996
Harold G. Danford, MD, Appleton, 1991/1994-1997
Charles E. Fenlon, MD, Appleton, 1988/1994-1997
Thomas C. Gabert, MD, Woodruff, 1994/1994-1997
Thomas J. Grau, MD, La Crosse, 1991/1994-1997
Charles E. Holmburg, MD, Menomonee Falls, 1994/1994-1997
Elizabeth T. Sanfelippo, MD, Milwaukee, 1990/1994-1997
Dianne L. Zwicke, MD, Milwaukee, 1987/1994-1997, chair
Jan P. De Roos, MD, Sheboygan, 1995/1995-1998
Vernon N. Dodson, MD, Madison, 1992/1995-1998
Warren J. Holtey, MD, Marshfield, 1990/1995-1998, vice chair
Kesavan Kutty, MD, Milwaukee, 1993/1995-1998
L. Cass Terry, MD, Ph.D., Milwaukee, 1990/1995-1998

Medical School Deans' designees:
Thomas C. Meyer, MD, UW-Madison
Timothy J. Van Susteren, Ph.D., Medical College of Wisconsin

Staff support: Kristin Krueger/Lisa Lawry

Environmental and Occupational Health
This commission shall be concerned with the health and safety of persons in relation to their environment and occupation.

John T. Bolger, MD, Waukesha, 1990/1993-1996
Larry A. Lindesmith, MD, La Crosse, 1993/1993-1996
Donald B. Lindorfer, MD, Waukesha, 1993/1993-1996
Thomas T. Midthun, MD, Baraboo, 1993/1993-1996
Marvin G. Parker, MD, Racine, 1994/1994-1996
David L. Drury, MD, Whitefish Bay, 1994/1994-1997
Michael J. Goldstein, MD, Monona, 1994/1994-1997
Julie N. Larsen, MD, Oconomowoc, 1992/1994-1997, vice chair
Mark C. Moore, MD, Madison, 1994/1994-1997
John J. Ouellette, MD, Madison, 1991/1994-1997
Mark A. Roberts, MD, Milwaukee, 1991/1994-1997, chair
Henry A. Anderson, MD, Madison, 1992/1995-1998
Al Baltrusaitis, DO, Brookfield, 1995/1995-1998
Gerald A. Bucholtz, MD, Marshfield, 1995/1995-1998
Jane K. Sliwinski, MD, Green Bay, 1990/1995-1998
Tuenis D. Zondag, MD, Eau Claire, 1994/1995-1998
Bryant Weber, Manitowoc, WMGMA representative
Gwen McIntosh, medical student, UW
Betty Kuplic, Sheboygan Falls, Alliance

Staff support: Lynn Sherman/Karen Baier

Geriatric Health
This commission shall be concerned with geriatric health care issues and services, the process of aging, and the means to achieve the best possible health status and care for the aged. This shall include services provided in nursing facilities and in the home.

Kae L. Ferber, MD, Madison, 1995/1995-1996
George Mathai, MD, Elm Grove, 1994/1994-1996
Edwin G. May, MD, Stevens Point, 1993/1993-1996
Mark A. Sager, MD, Madison, 1990/1993-1996
Thomas H. Williams, MD, Mukwonago, 1987/1993-1996
Scott S. Erickson, MD, Marshfield, 1994/1994-1997
Richard S. Kane, MD, Milwaukee, 1989/1994-1997, chair
Edward O. Lukasek, MD, Sparta, 1988/1994-1997
Thomas M. Naughton, MD, New Berlin, 1994/1994-1997
Henry M. Waldren, Jr, MD, Oconomowoc, 1995/1995-1997
Maury B. Berger, MD, Milwaukee, 1995/1995-1998, vice chair
Joseph N. Blustein, MD, Madison, 1992/1995-1998, vice chair
Gary J. Leo, DO, Milwaukee, 1993/1995-1998
Brian P. McSorley, MD, Milwaukee, 1995/1995-1998
Michael G. O'Mara, MD, Oconomowoc, 1994/1995-1998
Sarah de Grood, medical student, UW
Sandra Kontra, Racine, Alliance

Staff support: Lynn Sherman/Merry Earll

Governmental Affairs
This commission shall plan, organize, and implement programs to protect and preserve the legislative, socioeconomic, and political interests of the members of the State Medical Society of Wisconsin. The commission shall analyze state and federal legislation and administrative rules and policies, and recommend to the Board of Directors specific actions and positions designed to carry out this responsibility. The commission shall also inform the membership of the Society regarding proposed legislation and other public policy initiatives, seek the enactment of legislation for the best interests of the public, scientific medicine, and the medical profession, and promote and encourage Society members to be politically active individually and collectively. This commission shall act to protect the socioeconomic interests of the Society membership in public and private health care delivery systems and recommend to the Board of Directors specific strategies and efforts to achieve this purpose. This commission shall consist of members appointed by the Board of Directors in a number

deemed sufficient to execute the responsibilities delegated to the commission. Membership on the commission shall also include a representative from each of the specialty sections of the Society, subject to approval by the Board of Directors. These representatives shall be appointed by the sections annually, and shall have the right to vote on all matters before the commission. The President, President-elect, Immediate Past President, and Chairman of the Board of the Society shall serve as ex officio members of the commission with vote.

Mark H. Andrew, MD, Viroqua, 1990/1993-1996
Steven K. Dankle, MD, Milwaukee, 1990/1993-1996
Vernon N. Dodson, MD, Madison, 1985/1993-1996
James W. Hoftiezer, MD, Two Rivers, 1993/1993-1996
Ronald R. Martins, MD, Elm Grove, 1994/1994-1996
Timothy G. McAvoy, MD, Waukesha, 1987/1993-1996
Robert M. Stern, MD, Milwaukee, 1990/1993-1996
DeLore Williams, MD, Elm Grove, 1985/1993-1996
Gregory B. Buck, MD, Wauwatosa, 1990/1994-1997
James Embrescia, MD, Madison, 1994/1994-1997
Bruce A. Kraus, MD, Columbus, 1988/1994-1997, chair
John F. Pope, MD, Wauwatosa, 1994/1994-1997
Patrick L. Remington, MD, Madison, 1993/1994-1997
Thomas Slota, MD, Milwaukee, 1992/1994-1997, vice chair
Sridhar V. Vasudevan, MD, Brookfield, 1994/1994-1997
Evan K. Saunders, MD, Milwaukee, 1995/1995-1997
Gary L. Bryant, MD, La Crosse, 1993/1995-1998
Mehran Heydarpour, MD, Brookfield, 1995/1995-1998
Michael J. Kryda, MD, Marshfield, 1989/1995-1998
Larry M. Ojeda, MD, Beloit, 1989/1995-1998
William E. Raduege, MD, Woodruff, 1995/1995-1998
Mark A. Timm, MD, Menomonee Falls, 1995/1995-1998
Joseph E. Trader, MD, Manitowoc, 1989/1995-1998
Laurens D. Young, MD, Milwaukee, 1995/1995-1998
Alice Soule, Madison, WMGMA representative
Mary Weber, Fond du Lac, Alliance

President: Marcia J.S. Richards, MD, Milwaukee
President-elect: Richard H. Ulmer, MD, Marshfield

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AIR FORCE

Continued from preceding page
Immediate Past President: Richard G. Roberts, MD, Madison
Chair of the Board: Raymond C. Zastrow, MD, Milwaukee

Section representatives
Allergy Section: Donald A. Bukstein, MD, Madison
Anesthesiology Section: John F. Kreul, MD, Madison
Cardiology Section: Michael P. Cinquegrani, MD, Milwaukee
Dermatology Section: Eric R. Berg, MD, Madison
Emergency Medicine Section: Thomas J. Luetzow, MD, Watertown
Family Physicians Section: Calvin S. Bruce, MD, Madison
Internal Medicine Section: Susan L. Turney, MD, Marshfield
Neurology Section: Gamber F. Tegtmeyer, Jr, MD, Madison
Neurosurgery Section: Mohammed Rafiullah, MD, Racine
Obstetrics-Gynecology Section: Robert K. DeMott, MD, Green Bay
Ophthalmology Section: Jack L. Hughes, MD, Wauwatosa
Orthopaedic Section: Robert O. Buss, MD, Brookfield
Otolaryngology Section: Ashley G. Anderson, Jr, MD, Madison
Pathology Section: Katherine M. Bayliss, MD, Waukesha
Pediatrics Section: Donald C. Burandt, MD, Beloit
Physical Medicine and Rehabilitation Section: Keith B. Sperling, MD, Madison
Plastic Surgery Section: William A. Wood, MD, Madison
Preventive Medicine Section: Sidney Shindell, MD, Milwaukee
Psychiatry Section: Robert F. Goerke, MD, Milwaukee
Radiation Oncology Section: Howard J. Lewis, MD, Milwaukee
Radiology Section: Timothy T. Flaherty, MD, Neenah
Surgery Section: James A. Avery, MD, Fond du Lac

(Other Section Representatives to be appointed)

Staff support: Mike Kirby/Judy Frey

Health Care Financing and Delivery
This commission shall be concerned with all aspects of health care financing and delivery systems, including managed health care plans, and shall promote an ongoing dialogue on these issues with business, industry, labor and, when appropriate, government agencies. It shall also be concerned with access and financing issues for rural and inner city health.

Edward J. Coleman, MD, Green Bay, 1992/1993-1996
Daniel D. Gilman, DO, Milwaukee, 1993/1993-1996
Frank S. Guzowski, MD, Marshfield, 1993/1993-1996
Kenneth O. Johnson, MD, Milwaukee, 1993/1993-1996
Craig Larson, MD, Milwaukee, 1993/1993-1996
Rudolf W. Link, MD, Lodi, 1990/1993-1996
Bradley L. Manning, MD, Madison, 1995/1995-1996
John R. Petersen, MD, Wauwatosa, 1994/1994-1996
Clyde M. Chumbley, II, MD, Menomonee Falls, 1991/1994-1997
Charles V. Ihle, MD, Eau Claire, 1992/1994-1997
John E. Midtling, MD, Milwaukee, 1994/1994-1997
Kenneth I. Robbins, MD, Madison, 1994/1994-1997
Norman J. Schroeder, II, MD, Green Bay, 1989/1994-1997
Sidney Shindell, MD, Milwaukee, 1994/1994-1997
Gregory A. Shove, MD, Racine, 1994/1994-1997
Susan L. Turney, MD, Marshfield, 1995/1995-1997
Frank H. Urban, MD, Brookfield, 1993/1994-1997
John A. Frantz, MD, Monroe, 1995/1995-1998
Paul G. Harkins, MD, Marshfield, 1990/1995-1998
Peter R. Holzhauer, MD, Brookfield, 1993/1995-1998
Narendra M. Kini, MD, Milwaukee, 1994/1995-1998
John E. Kraus, MD, Marinette, 1995/1995-1998
Richard A. Leer, MD, Marshfield, 1995/1995-1998
Kermit L. Newcomer, MD, La Crosse, 1987/1995-1998, chair
Harry Prosen, MD, Milwaukee, 1994/1995-1998, vice chair
Jonathan W. Thomas, MD, Green Bay, 1995/1995-1998
Joan Albian, Milwaukee, WMGMA representative
Stephanie Wojtowicz, medical student, UW

Staff support: Kevin Wymore/Merry Earll

Medical Assistance Technical Advisory Committee (work group)
The SMS created this advisory group to work with the Bureau of Health Care Financing on issues of mutual concern regarding the Medicaid program. Issues for the group's consideration include: MA reimbursement, claims issues and the performance of EDS, copayments, MA/HMO's, prior authorizations and other regulatory requirements. This advisory group is a subcommitte of the Commission on Health Care Financing and Delivery, and any recommendations made by the subcommittee will be referred to the parent commission for review and approval.

Daniel D. Gilman, DO, Milwaukee, chair
Marc F. Hansen, MD, Madison
John A. Frantz, MD, Monroe
Charles V. Ihle, MD, Eau Claire
Russell F. Lewis, MD, Madison
Nancy Ness, MD, Mauston
Guenther P. Pohlmann, MD, Milwaukee, vice chair

Susan L. Turney, MD, Marshfield
Arlene L. Lueck, Madison, WMGMA representative
Kevin Piper, Madison, DHSS
Allison Pritchett, medical student, UW

Staff support: Kevin Wymore/Merry Earll

Injury Prevention and Control
This commission shall be concerned with the prevention and control of accidental and intentional injuries. It shall examine and recommend public safety measures for reducing the incidence of untimely injury or death resulting from, but not limited to, gun violence, domestic abuse, transportation accidents, fires, drowning and falls. The commission shall also examine and recommend measures for assuring effective emergency medical systems in Wisconsin.

James L. Concannon, MD, Kenosha, 1993/1993-1996, chair
Kevin J. Fullin, MD, Kenosha, 1994/1994-1996
Phiroze L. Hansotia, MD, Marshfield, 1992/1993-1996
Ralph F. Hudson, MD, Eau Claire, 1989/1993-1996
Frederick W. Blancke, MD, Madison, 1994/1994-1997
Larry E. La Crosse, MD, Mequon, 1994/1994-1997, vice chair
Bernard F. Micke, MD, Madison, 1994/1994-1997
Judith D. Pruski, MD, Fond du Lac, 1994/1994-1997
Joanne A. Selkurt, MD, Whitehall, 1994/1994-1997
Stephen W. Hargarten, MD, Milwaukee, 1995/1995-1998
Susan Kinast-Porter, MD, Monroe, 1995/1995-1998
William H. Perloff, MD, Madison, 1992/1995-1998
Maxine Omdahl, Racine, Alliance
Fe Abellera, Onalaska, Alliance

Staff support: Lynn Sherman/Karen Baier

Maternal and Child Health
This commission shall be concerned with all aspects of health in pregnancy, childbirth and children, with special emphasis on the reduction of maternal mortality and the prevention of disease or disability in children.

Patricia A. Barwig, MD, Milwaukee, 1990/1993-1996
Susan C. Fee, MD, Marshfield, 1991/1993-1996, chair
Jean Ricci Goodman, MD, Marshfield, 1993/1993-1996
Robert J. Jaeger, MD, Stevens Point, 1994/1994-1996
Cynthia L. Jones-Nosacek, MD, Milwaukee, 1993/1993-1996
Timothy J. O'Neil, MD, Columbus, 1991/1993-1996
Frederick J. Bartizal, Jr, MD, Neenah, 1995/1995-1997
John E. Inman, MD, Monroe, 1991/1994-1997
Murray L. Katcher, MD, PhD, Madison, 1988/1994-1997
John D. Kenny, MD, Madison, 1987/1994-1997
Jeffrey H. Lamont, MD, Wausau, 1994/1994-1997
James A. Meyer, MD, Marshfield, 1988/1994-1997, vice chair
Fredrik F. Broekhuizen, MD, Whitefish Bay, 1995/1995-1998
Paul R. Myers, MD, Neenah, 1992/1995-1998
Carolyn Ogland Vukich, MD, Madison, 1995/1995-1998
Catherine R. Ryan, MD, La Crosse, 1995/1995-1998
Helen Hacker, Marshfield, Alliance

Staff support: Kevin Wymore/Merry Earll

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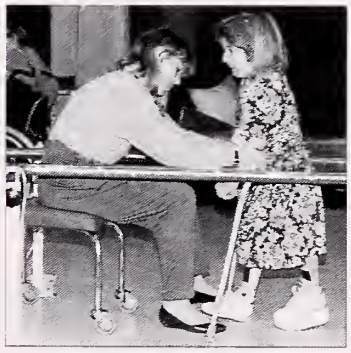

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GIVE ABILITY A CHANCE

Continued from preceding page

Study Committee on Maternal Mortality Survey
Gloria M. Halverson, MD, Waukesha, chair
Perry A. Henderson, MD, Madison
John E. Inman, MD, Monroe
Robert J. Jaeger, MD, Stevens Point
Stanley A. Korducki, MD, Milwaukee
Paul R. Meier, MD, Marshfield
Bernard B. Poeschel, MD, Eau Claire
Herbert F. Sandmire, MD, Green Bay
Walter R. Schwartz, MD, Wauwatosa
Dorothy V. Skye, MD, Rhinelander
Steven D. Stenzel, MD, Menomonie
E. Howard Theis, MD, Fond du Lac
Dennis Worthington, MD, Milwaukee

Staff support: Kevin Wymore/Merry Earll

Mediation and Peer Review
This commission shall receive, investigate, and seek to resolve differences between physicians and patients or other complainants, or between physicians, on matters relating to quality of care, and professional ethics. When necessary, it shall initiate disciplinary or other action as appropriate. It shall serve as the Society's advisory body to private or governmental organizations on matters affecting medical peer review including utilization review, appropriateness of care, and quality assurance. It shall advise and consult with component societies on issues of peer review, mediation, ethics, and discipline in concert with members of the Board of Directors. It shall serve as the initial appellate body for peer review and mediation issues that are appealed from local committees of component societies. It shall coordinate the Statewide Physician Health Program.

Philip J. Dougherty, MD, Menomonee Falls, 1987/1993-1996
Charles S. Geiger, Jr, MD, West Bend, 1993/1993-1996
Michael H. Gilman, DO, Milwaukee, 1994/1994-1996
Martin L. Lobel, MD, Milwaukee, 1993/1993-1996
Michael J. O'Neill, MD, Green Bay, 1987/1993-1996
David A. Satchell, MD, Manitowoc, 1990/1993-1996
Santiago L. Yllas, MD, Racine, 1987/1993-1996, vice chair
Bruce B. Berry, MD, Milwaukee, 1991/1994-1997
Fernando B. Bersalona, MD, Marshfield, 1994/1994-1997
Lucille B. Glicklich, MD, Milwaukee, 1994/1994-1997
Donald R. Gore, MD, Sheboygan, 1992/1994-1997, chair
James P. Long, MD, Beloit, 1987/1994-1997
George A. Pagels, MD, Marshfield, 1988/1994-1997
William A. Wood, MD, Madison, 1994/1994-1997
John E. Woodford, MD, Madison, 1992/1994-1997
Norval E. Bernhardt, MD, Madison, 1995/1995-1998
Frederick W. Blancke, MD, Madison, 1987/1995-1998
James R. Davidson, MD, Monroe, 1995/1995-1998
Kenneth O. Johnson, MD, Milwaukee, 1992/1995-1998
Richard D. Sautter, MD, Marshfield, 1992/1995-1998
Donald F. Weber, MD, Eau Claire, 1992/1995-1998
John B. Weeth, MD, La Crosse, 1992/1995-1998
Virgil L. Sharp, DO, Waterloo, representing the Wisconsin Association of Osteopathic Physicians and Surgeons

Staff support: Anne Bicha/Sonia Porter

Coordinating Council on Physician Impairment
Gerald C. Kempthorne, MD, Spring Green (SMS)
Fred H. Koenecke, Jr, MD, Richland Center (SMS)
Michael M. Miller, MD, Madison (SMS)
Wanda Roever, Slinger, public member (MEB)
Rudolfo Molina, MD, Beaver Dam (MEB)
Walter R. Schwartz, MD, Brookfield (MEB)

Staff support: John LaBissoniere/Sonia Porter

Managing Committee, Statewide Physician Health Program
Pauline M. Jackson, MD, La Crosse
Gerald C. Kempthorne, MD, Spring Green
Fred H. Koenecke, Jr, MD, Richland Center
Wesley E. McNeal, MD, Green Bay
Rebecca D.C. Niehaus, MD, Crandon
Michael M. Miller, MD, Madison
Marcia J. S. Richards, MD, Milwaukee

Medical Director, SPHP
David G. Benzer, DO, Wauwatosa

Staff support: John LaBissoniere/Sonia Porter

Medicaid Medical Audit
R. Marshall Colburn, MD, Oregon
Alfred D. Dally, MD, Madison
John A. DeGiovanni, MD, Prairie du Sac
Philip J. Dougherty, MD, Menomonee Falls
Richard W. Edwards, MD, Richland Center
Charles S. Geiger, Jr, MD, West Bend
Gerald C. Kempthorne, MD, Spring Green
D. Mark Lochner, MD, Waupaca
Kevin M. Roley, MD, Madison
David A. Satchell, MD, Manitowoc
Virgil L. Sharp, DO, Waterloo, representing the Wisconsin Association of Osteopathic Physicians and Surgeons
Daniel W. Shea, MD, De Pere
G. John Weir, Jr, MD, Marshfield

Staff support: John LaBissoniere/Sonia Porter

Medical Liability and Risk Management
This commission shall monitor current risk management developments and examine the range of options to reduce liability exposure.

W. Scott Carpenter, MD, Marshfield, 1993/1993-1996
Jerome W. Fons, Jr, MD, Greenfield, 1989/1993-1996
Kenneth M. Klatt, MD, Madison, 1993/1993-1996
Charles Schauberger, MD, La Crosse, 1993/1993-1996
Steven D. Stenzel, MD, Eau Claire, 1995/1995-1996
S. Marshall Cushman, Jr, MD, Racine, 1988/1994-1997
Donald L. Feinsilver, MD, West Allis, 1994/1994-1997
Thomas M. Kidder, MD, Milwaukee, 1987/1994-1997
Abraham Varghese, MD, Milwaukee, 1994/1994-1997
Michael A. Weiner, MD, Madison, 1994/1994-1997
Laurens D. Young, MD, Milwaukee, 1993/1994-1997
Gregory B. Buck, MD, Wauwatosa, 1993/1995-1998
Joseph C. DiRaimondo, MD, Manitowoc, 1990/1995-1998
Sidney E. Johnson, MD, Marshfield, 1987/1995-1998, chair
John J. Kelly, MD, Milwaukee, 1993/1995-1998
Steven L. Lawrence, MD, Wauwatosa, 1989/1995-1998
Daniel W. Shea, MD, DePere, 1993/1995-1998, vice chair
Alice Soule, Madison, WMGMA representative
Jeri Cushman, Racine, Alliance

Staff support: Anne Bicha/Karen Baier

Medicine and Ethics
This commission shall be concerned with the ethical aspects of medical practice in order to permit discussion of common problems in the total treatment and care of patients; and, to clarify the relationship between ethics and science in medicine.

Richard A. Dart, MD, Marshfield, 1993/1993-1996
Mary H. Frantz, MD, Monroe, 1995/1995-1996
Charles L. Junkerman, MD, Milwaukee, 1990/1993-1996
Kathryn P. Nichol, MD, Milwaukee, 1993/1993-1996, chair
Philip J. Dougherty, MD, Menomonee Falls, 1991/1994-1997
William J. Hisgen, MD, Madison, 1995/1995-1997
Russell F. Lewis, MD, Madison, 1994/1994-1997
John K. Scott, MD, Madison, 1990/1994-1997
Rodney W. Sorensen, DO, Marshfield, 1987/1994-1997
William G. Weber, MD, Oshkosh, 1991/1994-1997
Donald R. Beaver, DO, Wauwatosa, 1992/1995-1998
Kathleen M. Broad, MD, Superior, 1995/1995-1998
Steven H. Cohen, MD, Milwaukee, 1993/1995-1998
Wm. Michael Cross, MD, Green Bay, 1992/1995-1998
Armond H. Start, MD, Madison, 1993/1995-1998

Lynn Michel's harp enchanted guests at the SMS Presidential Inauguration.

Richard J. Thurrell, MD, Madison, 1990/1995-1998, vice chair
Henry M. Waldren, Jr, MD, Oconomowoc, 1995/1995-1998
Leah Speltz, Wausau, Alliance

Staff support: Maria Van Cleve/Karen Butler

Public Information
This commission shall be concerned with the members of this Society and their image with the public. It shall plan and execute programs of effective public information and health education, assist component societies in the conduct of similar programs, develop effective media relations.

Jane M. Collis-Geers, MD, Milwaukee, 1993/1993-1996
Robert E. Phillips, MD, Marshfield, 1993/1993-1996
Gary C. Steven, MD, Milwaukee, 1993/1993-1996
Jeffry J. Young, DO, Green Bay, 1993/1993-1996
Clarence P. Chou, MD, Mequon, 1991/1994-1997
S. Roger Hirsch, MD, Milwaukee, 1994/1994-1997
Bradley L. Manning, MD, Madison, 1991/1994-1997
Benjamin C. Wedro, MD, La Crosse, 1987/1994-1997, chair
Khosro Adib, MD, Madison, 1994/1995-1998
Michele L. Bachhuber, MD, Marshfield, 1993/1995-1998

Continued on next page

Edward G. Kass, MD, Waukesha, 1994/1995-1998
Roberta Baldwin, Watertown, Alliance

Staff support: Shari Hamilton/Lynne Bjorgo

Wisconsin Medical Journal
The *Wisconsin Medical Journal* shall be the official journal of the Society. An editorial board consisting of the medical editor as chair and no less than six additional members shall be responsible for all scientific, editorial, and business affairs of the Journal. An editorial director, serving as chair of a group of no less than five editorial associates, shall be responsible for regularly providing items of editorial opinion for publication in the editorial pages of the Journal.

Susan F. Behrens, MD, Beloit, 1991/1993-1996
Martin D. Hoffman, MD, Milwaukee, 1994/1994-1996
Kesavan Kutty, MD, Milwaukee, 1994/1994-1996
Thomas C. Meyer, MD, Madison, 1995/1995-1998, chair and medical editor
Donald S. Schuster, MD, Madison, 1991/1994-1997
Benjamin C. Wedro, MD, La Crosse, 1993/1994-1997
Charles C. Canver, MD, Madison, 1994/1995-1998
Jeffrey H. Lamont, MD, Wausau, 1989/1995-1998
Victor S. Falk, MD, Edgerton, medical editor emeritus

Staff support: Shari Hamilton/Lynne Bjorgo

WNA-SMS Liaison
This commission shall be concerned with developing recommendations, as appropriate, regarding education, legislation, practice arrangements and delivery patterns; shall facilitate understanding and acceptance by the professions and the public of changing medical and nursing relationships, roles and practices; shall serve as a consultation resource in matters that relate to joint practice.

SMS members:
Sandra L. Osborn, MD, Madison, 1990/1993-1996, co-chair
Charles E. Pechous, Jr, MD, Kenosha, 1993/1993-1996
Arthur E. Angove, DO, Milwaukee, 1995/1995-1998
Marc F. Hansen, MD, Madison, 1987/1995-1998

WNA members:
Barbara Friedbacher, RN, Brookfield
Vickie Gukenberger, RN, Wisconsin Rapids, co-chair
Barbara Nichols, RN, Madison
Ronnie Peterson, RN, Evansville
Leona VandeVusse, RN, Milwaukee

Staff support: Anne Bicha/Karen Baier

Task forces

Task Force on Quality Assessment and Implementation of Practice Parameters
To ensure that Wisconsin physicians assume a knowledgeable role in the continuing discussion of quality medical care, the task force shall review and monitor developments within each of the following areas: practice parameters; severity measurement systems, methods for continuous quality improvement and other systems for quality assessment and enhancement; and Wisconsin specific projects including the State Office of Health Care Information and the state pilots in the Health Care Financing Information and the state pilots in the Health Care Financing Administration's Ambulatory Review Project and Uniform Clinical Data Set Project. Further, the task force shall develop a plan for the future role of the Society in the assessment of quality and the implementation of practice parameters.

Philip J. Dahlberg, MD, La Crosse
Kevin T. Flaherty, MD, Wausau
Norman W. Hoover, MD, Milwaukee
Jerry M. Ingalls, MD, Monroe, chair
Nicholas E. Mischler, MD, Madison
George A. Pagels, MD, Marshfield
Thomas A. Reminga, MD, Milwaukee
Ayaz M. Samadani, MD, Beaver Dam
Peter A. Sanderson, MD, Plover
John O. Simenstad, MD, Osceola
Bruce Kruger, Madison, WMGMA representative

Staff support: Sally Wencel/Merry Earll

Medical Schools/SMS Relations Committee
To reach areas of commonality and understanding and to develop an agenda to determine what should comprise the practice of medicine in the year 2000.

The effort to coordinate medical school activities with the profession warranted this commitment to listen and educate its leadership on problems facing the colleges.

SMS members
Ashley G. Anderson, Jr., MD, Madison
Patricia A. Barwig, MD, Milwaukee
Clyde M. Chumbley, II, MD, Menomonee Falls
James L. Concannon, MD, Kenosha
J. Timothy Harrington, Jr., MD, Madison
Richard A. Leer, MD, Marshfield
Albert J. Motzel, Jr., MD, Waukesha
K. Kwang Soo, MD, Milwaukee
Robert S. Witte, MD, La Crosse

MCW members
Edmund H. Duthie, MD, Milwaukee

Stanley Kaplan, PhD, Milwaukee
Janet C. Lindemann, MD, Milwaukee
David Schiedermayer, MD, Milwaukee
Alonzo Walker, MD, Milwaukee

UW members
Paul P. Carbone, MD, Madison
Theodore Goodfriend, MD, Madison
Richard Helgerson, MD, Madison
Susan Skochelak, MD, Madison

Staff support: Kristin Krueger/Lisa Lawry

Committees of the Board

Executive
Marcia J.S. Richards, MD, Milwaukee
president of the Society
Richard H. Ulmer, MD, Marshfield
president-elect of the Society
Richard G. Roberts, MD, Madison
immediate past president of the Society
Raymond C. Zastrow, MD, Milwaukee
chair of the Board
Mark H. Andrew, MD, Viroqua
vice chair of the Board
Harry J. Zemel, MD, Fond du Lac
chair of the Finance Committee
Sandra L. Osborn, MD, Madison
speaker of the House of Delegates
Robert F. Purtell, Jr, MD, Milwaukee
director at large
Robert L. Sellers, MD, Superior
director at large
Ex Officio non-voting members:
Cecilia Podlusky, Appleton
Alliance president
Mary El Kastelic, Elm Grove
Alliance president-elect

Finance
Harry J. Zemel, MD, Fond du Lac, chair
David J. Deubler, MD, Kiel
Stephen D. Hathway, MD, Green Bay
Jerry M. Ingalls, MD, Monroe
Jack M. Lockhart, MD, La Crosse
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Expense reimbursement policy and procedure for physicians on SMS business

It is SMS policy to offer reimbursement of out-of-pocket expenses incurred by its officers, directors, speaker, vice-speaker, committee chairs and members, AMA delegates and alternates and other designated physicians when such expenses are incurred in the course of the conduct of business on behalf of the society. The society recognizes that any such leadership role requires a substantial contribution in personal time on the part of the physician. Traditionally, this has been accepted as a contribution to the profession and the health of the public. Out-of-pocket expenses in the discharge of official functions of the society are, however, reimbursable as set forth below, except that district directors are not reimbursed for the expense of attending the annual meeting of the society (Bylaws, Chapter V, Sec 4).

Officers, directors, committee chairs and members, and other designated persons

Reimbursable expenses include the cost of:

- All meals, including normal tips, incurred while away from the physician's home city on SMS business.
- All meals in the home city of the physician when these are in relation to an SMS business meeting.
- Entertainment expenses where such expense is clearly a proper and necessary adjunct to the conduct of the physician's business function for the society.
- Valet and laundry services when the physician is away from home city on SMS business continuously for 4 days or more.
- Lodging for those days (nights) reasonably associated with the dates of a meeting for which expenses are claimed.
- Transportation from home city to meeting site and return as follows:

  Air. Cost of round trip coach airfare, plus necessary ground transportation.

  Bus or train. Cost of round trip fare, plus necessary ground transportation.

  Auto. Mileage at the current SMS rate (now $.30) to and from the meeting site, plus necessary parking fees and highway tolls.

  Miscellaneous ground transportation. Local bus and cab fares as necessary.

  Auto rental. All or some portion of such cost may be reimbursed as a substitute for other ground transport when this is the most feasible alternative following initial air, bus or train travel.
- Telephone, fax and telegraph communications relative to SMS business.
- Secretarial and copying services, postage and stationary used for SMS business. (Note: SMS headquarters is prepared to handle most official correspondence and reproduction work for officers and committee members. Physicians may be reimbursed, however, for personal or office costs relating to secretarial, copying, postage and stationery used in conducting SMS business. Copies of all official correspondence should be sent to the appropriate committee staff person at SMS, so as to assure proper coordination and record-keeping.
- Expenses, as described above, incurred by the president's and president elect's spouses when accompanying in an official ca-

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pacity, or when the spouse is expected to be in attendance, are reimbursable.

Procedure for claiming expenses. To obtain reimbursement, submit a statement of expenses incurred within ninety (90) days from the date the expenses were incurred. Attach copies of bills or receipts for all lodging, travel, and meals over $25. Itemize separately costs for the eighth item above. Mail to SMS Business Services and Support, PO Box 1109, Madison, WI 53701. Reimbursement will be made within two weeks following receipt and approval of the expense report. Expense statements received after the 90-day period will not be reimbursed.

In 1995, the House of Delegates authorized the payment of expenses for resident and student delegates and alternate delegates to attend the annual meeting as approved by the Board.

AMA delegates and alternates
AMA delegates and alternates (including the young physicians delegate and alternate) from Wisconsin receive reimbursement as follows for each meeting to the AMA House of Delegates they attend:

- Round trip economy air fare (advance booking strongly suggested.)
- Actual cost of room (mid-range) for 5 nights at the annual meeting, and 4 nights at the interim meeting.
- A per diem (currently $60) for food and all incidentals for 6 days at the annual meeting, and 5 days at the interim meeting.
- When AMA delegates and alternates are conducting SMS business not in conjunction with meetings of the AMA House of Delegates, their expenses may be reimbursed in the same manner as outlined for officers and directors.

Out-of-state trips
To receive reimbursement for out of state travel members must have prior approval by the Chairman of the Board of Directors and the Executive Vice President. Travel to the AMA House of Delegates meetings by the above mentioned and travel by the SMS President and President Elect are exempt from this policy.❖

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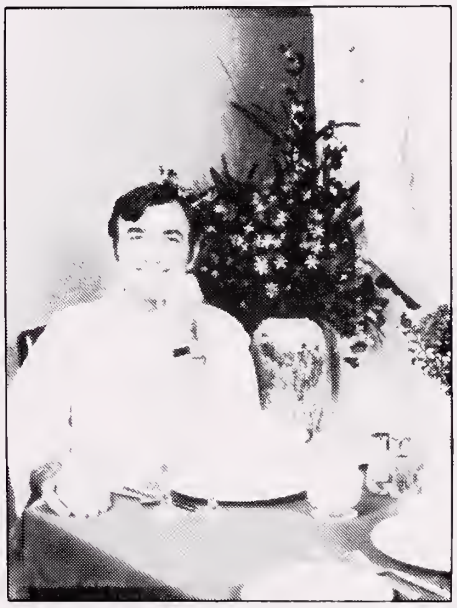

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SMS financial report

The following financial statements of the State Medical Society of Wisconsin are part of the treasurer's report to the House of Delegates. The annual certified audit, prepared by Grant Thornton, independent certified public accountants, is on file at Society headquarters. Members may review the audit by inquiry to the SMS executive vice president.

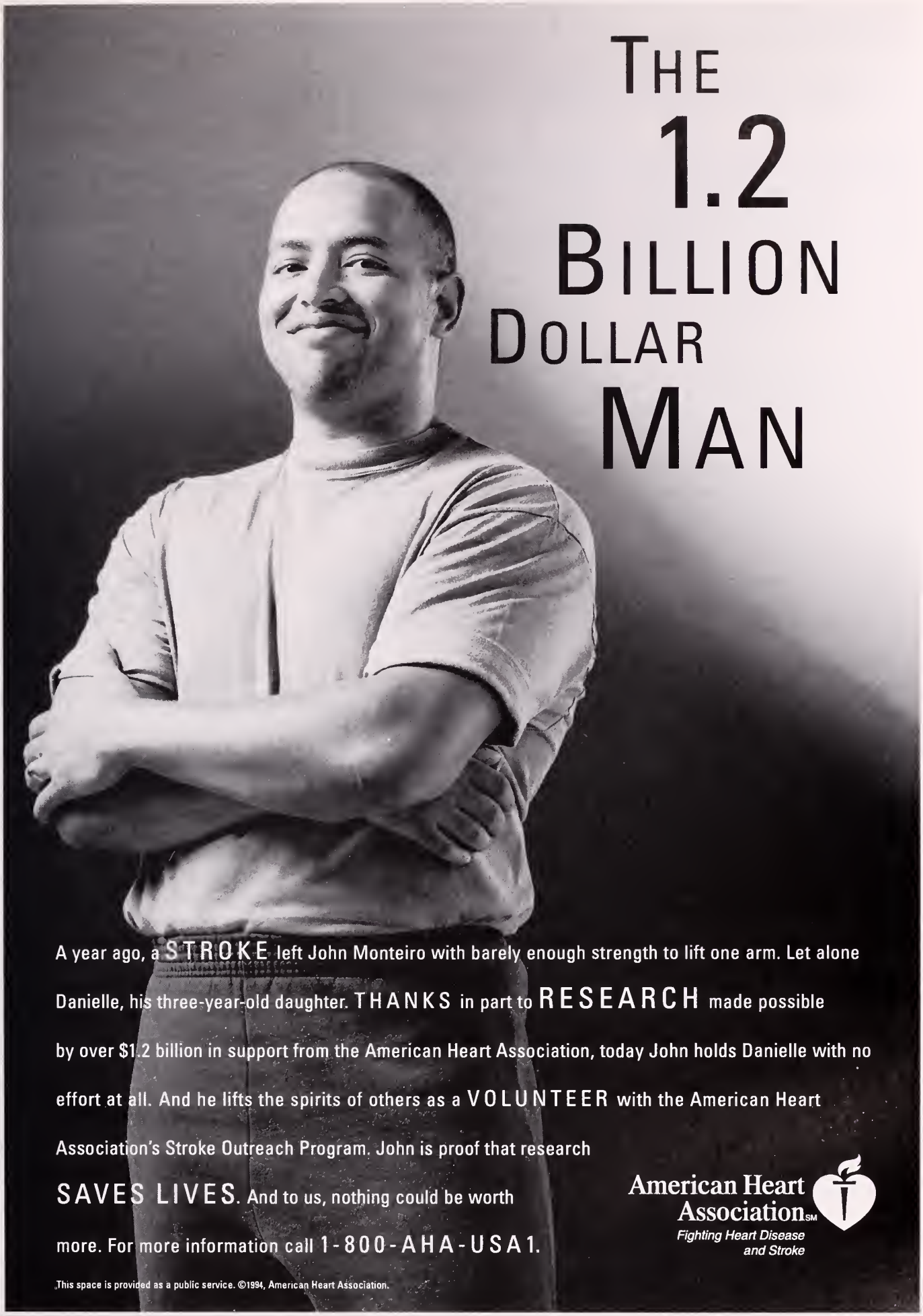
Balance sheet
Dec 31, 1994

Assets	
Current assets	
Cash and cash equivalents	$ 3,154,396
Investments	680,795
Accounts receivable	
Trade	70,599
Due from affiliates	120,800
Prepaid expenses	43,044
Total current assets	$ 4,069,634
Property and equipment—at cost	
Building and equipment	$ 2,649,074
Furniture and equipment	1,375,615
Capitalized lease equipment	177,658
Less accumulated depreciation	(2,107,553)
Land	68,686
Total property and equipment	$ 2,163,480
Other assets	
Rental property, net of accumulated depreciation	$ 1,871,459
Long-term investment	249,000
Cash value of life insurance	2,579
Investment in subsidiary	91,184
Deferred compensation plan assets	378,309
Notes receivable	100,000
Total other assets	$ 2,692,531
Total assets	$ 8,925,645
Liabilities	
Current liabilities	
Current maturities of long-term debt	$ 137,689
Trade accounts payable	131,495
Dues payable to other organizations	956,614
Accrued payroll and vacation pay	177,385
Accrued property, payroll and sales taxes	180,051
Deferred revenues	3,089,668
Accrued health plan costs	27,000
Other	33,737
Total current liabilities	$ 4,733,639
Long-term debt less current maturities	$ 644,293
Deferred compensation payable	$ 377,002
Accrued Pension Costs	$ 35,456
Membership equity	$ 3,135,255
Total liabilities and membership equity	$ 8,925,645

Statement of income and expenses
Year ended Dec 31, 1994

Income	
Membership dues	$ 3,574,165
Sales and services	1,138,124
Investment	100,252
Royalty	262,578
Loss on investments	(109,624)
Rental	292,906
Other grants	48,411
Other	427
Total income	$ 5,307,239
Expenses	
Payroll and employee benefits	$ 2,828,595
Travel and conference	636,400
General and administrative	1,073,549
Occupancy	399,810
Professional fees and outside services	350,654
Pension	193,827
Interest	80,681
Other	25
Total expenses	$ 5,563,541
Excess of expenses over revenues	$ (256,302)
Equity at Jan 1, 1994	$ 3,453,156
Equity in loss of subsidiary	$ (61,599)
Equity at Dec 31, 1994	$ 3,135,255

❖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Charter law of the SMS

Chapter 148

148.015 State society.(1) The State Medical Society of Wisconsin is continued with the general powers of a corporation. It may, from time to time adopt, alter and enforce constitution, bylaws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

148.02 County societies. (1) The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists, may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the medical examining board, shall be entitled to meet for organization or become members of the county medical society.

(3) If there is not a sufficient number of physicians and surgeons in any county to form a county medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than 15 adjoining counties may organize a county medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, bylaws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, bylaws and regulations of the state society.

148.03 Service insurance corporations for health care. The state medical society or, in a manner approved by the state society, a county society, may establish in one or more counties of this state a service insurance corporation for health care under ch. 613.

Note on §148.03, 447.13, and 449.15: Chapter 613 provides in general terms for the creation, governance and regulation of service insurance corporations for any kind of health care, as well as for other types of services. All that is needed in each authorizing chapter for professional societies is a brief section giving the appropriate professional society the power to organize a ch. 613 corporation. Section 148.03 creates that section for health care.

One basic restriction results from the repeal of the old enabling sections: none of the professional societies will be able to organize a service insurance plan within its own corporate structure. It is a mistake to permit such a mixing of professional and insurance activities within the same corporation. The society can, of course, control the service insurance corporation it creates under ch. 613, but the service insurance corporation will be legally separate. This will lead to more effective (and appropriate) control by the insurance commissioner, who should neither be empowered nor compelled, as arguably he was under the old statutes, to have any concern about the purely professional activities of the societies, because of the impossibility of disentangling the insurance and professional activities carried on by a single corporation.❖

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SMS Constitution and Bylaws

Constitution

Article I
Name of the association

The name and title of this organization shall be the State Medical Society of Wisconsin.

Article II
Purpose

The purpose of the Society is to bring together the physicians of the state of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws. As used in the Constitution and Bylaws, "physician" means a doctor of medicine or a doctor of osteopathy licensed in Wisconsin.

Article III
Component societies

Component societies shall consist of those county medical societies chartered by the House of Delegates of this Society.

Article IV
Composition of the association

This Society shall consist of members who shall be the members of and certified by the component county medical societies; and whose dues and assessments for the current year have been received by the Society executive vice president in accordance with the schedule provided in the Bylaws.

Article V
House of Delegates

The House of Delegates shall be the legislative body of the Society and shall consist of:

(1) delegates elected by the component county medical societies,
(2) one delegate representing each specialty section of the Society, and one or more delegates representing each of the two medical student special sections, organized under the Bylaws,
(3) a speaker,
(4) a vice speaker.

The officers of the Society enumerated in Article IX of this Constitution, directors, and past presidents of the Society shall be ex officio members, but without the right to vote, except that if they have been duly seated as delegates, they shall have the right to vote. The speaker and vice speaker shall be elected by and from the House of Delegates for two-year terms, and shall be limited to three consecutive full terms in their respective offices. While holding these offices, they shall be members of the House at large and shall not represent any component county society or specialty society.

Article VI
Board of Directors

The Board of Directors, hereinafter referred to as "Board," shall have full authority and power of the House of Delegates between sessions of the House. It shall consist of the directors, immediate past president, president, president-elect, treasurer, speaker and vice speaker of the House of Delegates. The executive vice president shall be an ex officio member of the Board, but without the right to vote. A majority of its voting members shall constitute a quorum. Directors shall be elected from eight geographic districts whose boundaries shall be determined by the House of Delegates. There shall be elected one director from each district. In addition, there shall be elected director(s) from each district based on a formula using the number of members in each district as the numerator and the total membership of the Society as the denominator, rounded to the nearest whole number. This calculation shall be made every third year, and, as nearly as possible, is to provide for no more than 31 district directors and shall be based on the year end membership totals. The number of directors established for each district shall be approved by the Board and shall be reported to the districts by the executive vice president before annual elections to the Board. As nearly as possible, one-third of the members of the Board shall be elected each year. Each director shall be nominated and elected only by the elected delegates of the county medical society or societies from the district in which the director's principal place of practice is located. Such election shall be subject to the approval and confirmation of the House of Delegates. The terms of the directors shall be for three years. No individual shall be permitted to serve more than three consecutive three-year terms as director, and no more than a total of six terms of service as director shall be permitted.

Article VII
Specialty sections

The House of Delegates shall provide for a division of the Society into specialty sections.

Adopted as amended by the House of Delegates, April 1995.

Article VIII
Meetings

Section 1. The Society shall hold an annual meeting, at which time the House of Delegates shall meet to conduct its business. The annual meeting may also include scientific sessions as determined by the Board.

Sec 2. The place for holding each annual meeting shall be fixed by the House of Delegates, or by failure to act, such authority is delegated to the Board. The time and the place for holding each annual meeting shall be approved by the Board.

Sec 3. Special meetings of the House of Delegates shall be called by the speaker on written request of twenty delegates representing at least 10% of the component county medical societies, or on request of a majority of the Board. When a special meeting is called, the speaker shall set the time and place. The executive vice president shall mail a notice to the last known address of each member of the House of Delegates at least twenty days before the date of the special meeting. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall consider no business except that for which it is called.

Article IX
Officers

Officers of this Society shall be a president, a president-elect, an executive vice president, and a treasurer. The president-elect and treasurer shall be elected annually by the House of Delegates. The executive vice president shall be elected and the treasurer shall be nominated annually by the Board. The president-elect shall automatically succeed to the office of president at the conclusion of the term as president-elect. The treasurer shall be limited to nine consecutive terms and must be a director of the Board. No person shall hold more than one of the following offices concurrently: president, president-elect, executive vice president, treasurer, speaker, vice speaker, director, except that the treasurer is a member of the Board. Incumbents shall serve until their successors are elected and installed.

Article X
Funds and expenses

Funds may be raised by annual dues or by assessment on the members, or in any other manner approved by the House of Delegates. The House may establish regular and special classifications of membership. Dues, if any, shall be applied equitably to all members in each class. All resolutions adopted by the House of Delegates providing for appropriations shall be referred to the Board for implementation. All expenditures approved by the Board shall be included in the annual budget.

Article XI
Referendum

The House of Delegates may, by a two-thirds vote of those registered at that session, submit any question to the membership of the Society for its vote, except amendments to the Constitution. Such amendments are governed by Article XIII. The House shall determine prior to submission whether a referendum shall be advisory or binding, and so advise the membership at the time of submission. A majority vote of all the members of the Society shall determine the question on a binding referendum.

Article XII
Seal

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

Article XIII
Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual meeting, provided that such amendment shall have been introduced in the form of a constitutional amendment in open session at the previous annual meeting, and that it shall have been published at least once during the year in the Journal of this Society, or sent to each member of the Society at least two months before the meeting at which final action is to be taken.

Bylaws

Chapter 1
Membership

Section 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of the county society, shall be prima facie evidence of membership and of the right to benefits.

Sec 2. No person whose name has been dropped from the roll of members of a component society or this Society shall be entitled to any of the rights or benefits of this Society, except that such rights and benefits shall continue during the period of an appeal by such person to the Board of Directors.

Sec 3. Every physician who holds a license to practice medicine and surgery in Wisconsin shall be eligible to apply for membership. Each county society shall be the judge of the initial and continuing qualifications of its members, as well as the appropriate membership classification, subject to review and final decision by the Board of this Society. Members

will conduct themselves in a manner which is not in conflict with the purposes for which the Society is organized and is operating.

Sec 4. By provision of its constitution or bylaws, a county society may require that an applicant shall have practiced within its jurisdiction for a period of one year as a condition for election to membership; or that an applicant may first be elected to membership for a term of one year only, then resubmit to election by vote of the county society without limitations as to term.

Sec 5. A member of a component society whose license has been revoked, suspended, non-renewed, or voluntarily surrendered, shall be immediately and automatically suspended from membership as of the date of revocation, suspension, non-renewal, or voluntary surrender, pending definitive action by the Board.

Sec 6. A physician's county society membership must be held in that county in which the physician's principal practice is located. However, a physician living near a county line may hold membership in that county most convenient for attending meetings, with concurrence of the component society in which the principal place of practice is maintained.

Sec 7. A member whose principal practice is moved from within the territorial limits of a component medical society to the territory of another component of the State Society shall not be eligible to continue membership in the first such society after the expiration of the calendar year in which such move shall have occurred. Such member shall, however, be eligible to apply for membership anew, or by transfer to the society into whose jurisdiction the principal practice has been moved. The member shall be given a written certificate of transfer for transmission to the secretary of the society in the county to which he has moved. Pending acceptance or rejection by the society in the county to which he has moved, such member shall be considered to be in good standing in the first society and in the State Society until the end of the period for which dues have been paid.

Sec 8. When the principal practice of a member in good standing in a component society is moved outside the borders of this state, active membership in such component society and in the State Society may be continued by fulfilling all requirements of membership except residence pending acceptance as a new or transfer member by the society of the area to which the practice has been transferred. The period of such continuing membership in this state shall cease upon acceptance by a society in the new area of practice, and shall in no event continue beyond two full calendar years after that in which the practice location has been transferred.

Sec 9. Membership classifications. Members defined in this section, except affiliates, shall have all the rights and privileges of the Society and shall pay dues and assessments, as indicated, as a requirement of continued membership.

A. *Regular.* Regular members of this Society consist of all the regular members in good standing of the component county societies.

B. *Special.* Included in this classification are the following categories of members who by virtue of their special circumstances are entitled to reduced dues or waiver thereof:

(1) *Part-time practice.* Any physician, regardless of age, who practices 1,000 hours or less during a calendar year, but does not qualify under section 9.B.(5), may upon application, recommendation by the county medical society, and approval by this Society, be placed in this special category.

(2) *Resident.* Physicians in approved training programs as hospital residents or as research fellows who are licensed to practice medicine and surgery in Wisconsin. Such special membership category can be maintained for a maximum of five (5) consecutive years.

(3) *Temporary Military Service.* Members who are inducted into the United States Military or Public Health Service and serve in such capacity for not more than five (5) years.

(4) *Associate.* Members who suffer a disability preventing them from practicing medicine with resulting serious financial reverses which would make the payment of dues a matter of personal hardship. Such membership shall be on an annual basis, upon recommendation of the county society and approval by the Board of this Society.

(5) *Retired.* Members who have retired completely from the practice of medicine, or who practice 240 hours or less during a calendar year, upon recommendation of the county society and approval by this Society.

(6) *Life.* Those members of the State Medical Society of Wisconsin who have been members of this or other state medical societies for fifty (50) years, or are past presidents of the State Medical Society of Wisconsin. They shall receive a certificate of Life Membership.

(7) *Honorary.* Members who have been elected to a similar classification by their county society because of outstanding contributions to the medical profession, upon approval by the Board of this Society.

(8) *Over Age 70.* Members who are age 70 effective January 1 of the following year.

C. *Affiliate.* Persons who are not otherwise eli-

gible for membership may become affiliated with this Society in one of the following categories. Their dues or assessments, as well as rights and privileges as affiliate members, shall be determined by the Board.

(1) *Candidate.* Upon application, a county medical society or this Society may confer upon any person then attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure the status of Candidate Member.

(2) *Scientific Fellow.* The Board may by invitation and unanimous consent confer upon any person engaged in teaching of or research in one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine or Osteopathy, the status of Scientific Fellow.

(3) *Emeritus.* Retired members who have chosen not to renew their license, at the discretion of the Board.

Sec 10. Dues and Assessments. Members shall pay dues and assessments as follows:

A. *Regular members:* full dues and assessments.

B. *Physicians in part-time practice or over age 70:* one-half of regular member dues and assessments.

C. *Physicians in residency or fellowship training:* dues and assessments are to be determined by the Board of Directors. Dues and assessments for all other categories shall be waived, except as may be determined by the Board for affiliate members.

Chapter II
House of Delegates

Section 1. Each component county society shall be entitled to send one delegate and one alternate to the House of Delegates for each forty regular and special members or majority fraction thereof in this Society, provided, however, that each county society shall be entitled to at least one delegate and one alternate from that county society. For purposes of this section, the number of members as of the close of the calendar year preceding the first session of the House of Delegates at the Annual Meeting shall determine the number of delegates to which a county society shall be entitled. The secretary of each county society will send a list of such delegates and alternates to the executive vice president of this Society by the end of each calendar year preceding the year in which such delegates are elected to serve.

Sec 2. One-fourth of the members of the House of Delegates registered, representing one-fourth of the county medical societies in the state, shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

Sec 3. The speaker shall preside at the meetings of the House of Delegates.

Sec 4. The vice speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice speaker shall officiate during the unexpired term.

Sec 5. The speaker shall appoint members of reference committees from among the members of the House of Delegates. These committees shall consider and make recommendations to the House relative to resolutions, reports of officers, reports of commissions and committees, financial and other matters germane to the business of the House. The speaker shall also appoint a credentials committee and such other committees as deemed necessary.

Sec 6. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body. No person who has served 12 or more consecutive years as a Wisconsin delegate to the AMA shall be eligible to serve another term unless the delegate will concurrently serve on any of the following American Medical Association Councils: Constitution and Bylaws, Medical Education, Medical Service, Ethical and Judicial Affairs, Long Range Planning and Development, Legislation, Scientific Affairs; or, the American Medical Political Action Committee Board of Directors.

Sec 7. The House of Delegates shall have authority to create committees for special purposes and to appoint members of the Society who need not be members of the House of Delegates. Such committees shall report to the House of Delegates, and their members may be present to participate in the debate on their reports.

Sec 8. It shall receive for appropriate action the annual reports of the treasurer, executive vice president, and chair of the Board of Directors.

Sec 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the executive vice president's office of the Society two months before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Board of Directors or any member thereof, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

Sec 10. All questions of an ethical nature brought before the House of Delegates shall be referred to the Board of Directors without discussion.

Chapter III
Annual election

Section 1. The House of Delegates, at its first session of the annual meeting, shall elect a Committee on Nominations consisting of one (1) delegate for each district, except that in any district having five hundred (500) or more regular and special members, there shall be elected one (1) additional delegate for each additional five hundred (500) members or majority fraction thereof. One (1) delegate representing the specialty sections shall also be appointed. Nominating committee members shall be limited to six (6) consecutive terms. Those committee members who have served six (6) consecutive terms upon adjournment of the final session of the 1994 House of Delegates annual meeting and following years shall have met this requirement. This committee shall become operative at the close of the final session of that annual meeting and shall function until the close of the final session of the following year's Annual Meeting. The incoming committee shall meet with the existent committee but without vote during the overlapping days of the annual meeting. Any vacancy occurring in the Committee on Nominations between the date of its formation and the time of its reporting shall be filled by appointment by the director or directors of the district in which the vacancy occurs, or if a nominating committee member is unable to attend a nominating committee meeting or is a candidate for an office a substitute for that member shall be named by the most senior director available from the affected district by written notification to the executive vice president prior to the meeting of the nominating committee, provided that if the vacancy or need for substitution occurs in the representation from the specialty sections, such vacancy or substitution shall be filled by ballot from among the section delegates. The Committee on Nominations shall convene at least two (2) months prior to the annual meeting of the House of Delegates to prepare a slate of candidates. This meeting, to be held at a time, date and location published to the general membership at least two (2) months before this meeting, shall include an open session of not less than one (1) hour to allow individual nomination of candidates. The Committee shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the name of the Board nominee for treasurer and the names of one or more members for each of the other positions to be filled.

Sec 2. The report of the Committee on Nominations and elections shall be the first order of business of the House of Delegates at the third session of the annual meeting.

Sec 3. The House of Delegates shall elect the president-elect, the treasurer, the speaker and vice speaker of the House of Delegates, and the delegates and alternates to the American Medical Association. Where there is no contest, a majority vote without ballot shall elect. All other elections shall be by separate ballot for each individual position, and a majority of the votes cast shall be necessary to elect. If no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped, except where there is a tie, and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of the votes cast.

Sec 4. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

Chapter IV
Duties of officers

Section 1. The president is the chief constitutional officer of the Society. Within the limits of the Constitution, Bylaws, and policies of the House of Delegates and Board of Directors, the president shall have the following responsibilities and commensurate authority:

a. deliver an annual address to the House;
b. serve as a member with right to vote on the Board;
c. preside at meetings of the Executive Committee of the Board;
d. participate, ex officio and without the right to vote, in sessions of the House;
e. initiate and propose policies and programs that will further the goals and objectives of the Society for consideration by the House, Board, commissions and committees;
f. support and articulate policies and programs adopted by the Board and the House.
g. promote physician interest and active participation in the Society.

Sec 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant, the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect, the Board shall appoint one of its members as acting president until the next meeting of the House of Delegates.

Sec 3. The treasurer shall be responsible to the Board of Directors, and shall advise and assist it in making decisions on investment policy and financial matters. The duties of the treasurer shall include the following:

a. Be responsible for all funds due the Society, together with bequests and donations;
b. Pay money out of the treasury only on written order of the secretary;

c. Subject the treasurer's accounts to such examination as the House of Delegates may order;
d. Annually report on the financial standing of the Society, including a balance sheet and income and expense report;
e. Give bond in such amount as the Board may provide.
f. Serves as chair of the Finance Committee of the Board.

Sec 4. The executive vice president is the chief executive officer of the Society charged with the execution of policy as created and defined by the House of Delegates and the Board of Directors. The executive vice president shall serve as an ex officio, nonvoting member of the Board; be responsible to the Board and serve as its secretary; assist the Board and officers in making decisions and implementing actions; share convictions and argue their merits; perform the functions ordinarily assigned to the office of executive vice president, and make an annual report to the House of Delegates. "As chief executive officer the executive vice president shall, within the limits of the Constitution and Bylaws and Board operating policies, effectively perform the general managerial function for the Society and all of its divisions, activities, and personnel including employment and, as necessary, termination of all employees; be responsible for and have the necessary authority to direct, supervise, and coordinate all programs, projects and major activities of the Society and all wholly owned subsidiaries; formulate and recommend for approval of the Board basic policies and programs which will seek to achieve the objectives and goals of the Society; fully inform the Board on the condition and operation of the association; cooperate with the Board and Treasurer in establishing a program of fiscal responsibility for the Society including development, recommendation and upon approval, operation within an annual budget; act to insure that all funds, physical assets, and other property of the Society are appropriately safeguarded and administered; develop and maintain effective internal and external communications with the membership and other organizations and agencies, both public and private, so as to enhance the positions of the Society and the objectives of its membership; and through effective management and leadership, achieve economic, productive performance, forward-looking programming, and constructive growth of the Society."

Note: Following adoption of this Bylaw change (Sec. 4 above) in 1987, the Board agreed to develop and maintain a set of current "operating policies" between itself and the secretary to detail the more specific duties and expectations important to a good working relationship between the Board and the secretary.

Chapter V
Board of Directors

Section 1. The Board of Directors shall be the executive body of the Society. Between meetings of the House of Delegates it shall exercise the power conferred on the House of Delegates by the Constitution and Bylaws.

Sec 2. The Board shall meet during the annual meeting and at such other times as necessity may require, subject to the call of the chairman or on petition of three directors. It shall hold an annual meeting for purposes of organization and other business.

Sec 3. The Board shall elect a chairman and a vice chairman from among its voting members. It may create such further offices or combine or abolish them as it sees fit in the management of its affairs and in the discharge of its responsibilities. Its chairman shall submit an annual report to the House of Delegates including all major actions and policy decisions of the preceding year.

Sec 4. Each director shall be the organizer and mediator for the district. Directors shall visit each county in their district as needed for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep informed of the activities of the component societies in the district. Each director shall arrange for an annual conference or caucus with the societies or their delegates within the district, at which time information shall be disseminated concerning the activities of the State Medical Society and component societies within the district. Each director shall report as necessary to the Board. The necessary traveling expenses incurred by each director in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include the expense of attending the annual meeting of the Society.

Sec 5. The Board of Directors shall be the judicial body of the Society. It may decide any questions of conduct or discipline of members, or any questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. It shall develop and publish procedures for discipline, including denial of initial or continuing membership, for those physicians who fail to provide quality health care, failure to pay dues, loss of license to practice, or other cause. Its decisions in all cases shall be final, including the right to expel a member should a component society fail to do so after being so requested by the Board. The Board's right to original jurisdiction includes but

is not limited to the right to decide cases when:

a. the affected parties reside within the boundaries of a single county medical society and that society does not wish to assume jurisdiction;
b. the affected parties reside in two or more component medical society jurisdictions. The Board also has within its authority the right to appoint a commission or commissions to which any or all such matters may be referred for investigation, evaluation and decision to acquit, admonish, or otherwise discipline as appropriate. A member may appeal to the Board the decision of such commission or the action of a county society as provided in Chapter X, Section 3. If the recommendation is for suspension or expulsion of a physician from Society membership, final action must be taken by the Board.

Sec 6. Charters shall be issued to county societies only on approval of the Board, with ratification by the House of Delegates, and shall be signed by the president and executive vice president of this Society. Upon the recommendation of the Board, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Sec 7. In sparsely settled sections, the Board shall have authority to organize the physicians of two or more counties into societies. These societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Sec 8. The Board shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have the authority to appoint an editor of the Journal and such assistants as it deems necessary.

Sec 9. The Board shall select a qualified independent accounting firm and receive an annual audit of all accounts of this Society. With the treasurer, it shall supervise the investment of funds. The Board shall adopt an annual budget providing for the necessary expenses of the Society.

Sec 10. The Board may, by interim appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates. The appointee shall serve until a successor has been elected and has qualified. When a district initially qualified for an additional director, such position shall be considered new and not a vacancy to which the Board is authorized to make an interim appointment. Such new position shall be filled by election at the next meeting of the House of Delegates in the manner provided by Article VI of the Constitution. The initial term shall be so established as to maintain the election of substantially one-third of the directors each year.

Sec 11. The Board may elect as executive vice president one who need not be a physician or a member of the Society.

Sec 12. The Board shall provide such facilities for the Society as may be required to properly conduct its business.

Sec 13. The Board shall nominate a director to serve as treasurer and shall report the nominee to the Committee on Nominations in the manner provided by Chapter III of the bylaws.

Sec 14. There shall be an Executive Committee of the Board which shall consist of the president, the president-elect, the immediate past president, the chair and vice chair of the Board, the chair of the Finance Committee, the speaker, and two additional district directors to be appointed annually by the chair of the Board. The Alliance president and president-elect shall be ex-officio non-voting members. The Executive Committee shall possess and may exercise all the powers of the Board of Directors between meetings of the Board. The Executive Committee shall meet prior to the meetings of the Board and at such other times as may be required, subject to the call of the chair or on petition of three voting members, and shall report all actions taken by it to the next meeting of the Board, for its consideration.

Chapter VI
Commissions and committees

Section 1. The Board shall appoint such commissions and committees, either permanent or ad hoc, as it deems necessary to properly conduct the affairs of the Society. Membership on such committees and commissions shall be limited to members of the Society and its Alliance. Nonmembers of the Society or its Alliance may be appointed as special representatives should their expertise and knowledge be of benefit to the goals of such commissions or committees. Such individuals shall not have the right to vote or hold office. Each commission and committee shall have the duty of being informed on matters within the area of its special interest. They shall represent the Society's interests by continual contacts with voluntary and governmental agencies having related concerns with the intention of coordinating efforts to serve the health interests of the people of Wisconsin. They shall develop recommendations from their studies and activities for action by the Board or House of Delegates.

Sec 2. Specialty sections shall be regarded as special committees of the Society from which the Board or any commission or committee may seek advice and assistance on matters of special or general concern to the profession and the health of the people of Wisconsin. The specialty sections will be expected

to give special requests prompt consideration and response so as to enable the Society to make maximum use of their resources.

Chapter VII
Dues and assessments

Section 1. The annual dues and assessments of this Society shall be determined by the House of Delegates and shall be levied per capita on the members. Dues and assessments shall be payable as determined by the Board of Directors. Any member whose current year's dues have not been received by the executive vice president on or before the dues payment deadline, as established by the Board of Directors, shall be deemed in arrears and shall be removed from the membership rolls of the county society and this Society until such time as full dues for the current year have been received.

Sec 2. The record of payment of dues and assessments on file in the offices of this Society shall be final as to the fact of payment by a member and to the right to participate in the business and proceedings of the Society or the House of Delegates and to any other benefits and privileges of membership.

Chapter VIII

The Board of Directors shall adopt ethical guidelines for the members of this Society.

Comment: On July 18, 1981 the Board of Directors adopted the Principles of Medical Ethics of the AMA as the ethical guidelines of the Society.

Chapter IX

The current edition of Sturgis Standard Code of Parliamentary Procedure governs this organization in all parliamentary situations that are not provided for in the law or in its charter, constitution, bylaws, or adopted rules.

Chapter X
County societies

Section 1. All present county societies or those that may hereafter be organized in this state shall, upon application to the Board of Directors, receive charters from this Society, provided that their constitutions and bylaws have been submitted to the Board and found in conformity with the Constitution and Bylaws of the State Medical Society. All revisions shall be submitted to the Society, approved by the Board, and filed with the executive vice president. Where a county society has lost or misplaced its constitution and bylaws, the model constitution and bylaws for county medical societies, as last approved by the Board, shall be deemed to apply.

Sec 2. Only one component medical society shall be chartered in each county.

Sec 3. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Board of Directors of the State Society. Its decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Board of the State Society for final determination. The mechanisms and procedures which apply to the appeal process shall be those adopted by the Board.

Sec 4. Each component county society shall elect one or more delegates and may elect an equal number of alternates to substitute for any absent delegates from that component society, for a term of two calendar years, to represent it in the House of Delegates of this Society, in accordance with Chapter II, Section 1, of these Bylaws. The term of office shall begin on January 1 of the year succeeding the election of such delegates and alternates.

Sec 5. The secretary of each county society shall keep a roster of its members.

Chapter XI
Specialty sections

Section 1. The House of Delegates shall establish specialty and special sections within the Society. It shall have the power to combine, enlarge, or discontinue any or all of such sections so established using the following guidelines:

a. For specialty section to be designated it must represent a specialty which is represented in the American Medical Association House of Delegates and
b. Have at least twenty (20) members of the specialty who are members of this Society.
c. If no representative from the specialty section registers as a representative of that section for three (3) consecutive annual meetings, the specialty section will be dropped with the option of reapplying after one year, provided the above criteria are met.
d. From time to time special sections not meeting the above criteria may be established by the House of Delegates.

Sec 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest. Qualifications for membership in any section shall be established by the members of such section, subject to approval of the Board of Directors, Scientific meetings of a section shall be open to all members in good standing of the State Medical Society.

Sec 3. The officers of each section shall be elected by and from its membership. The terms of such officers shall be for one year, but any officer may be

reelected.

Sec 4. No section shall have the power to bind the State Medical Society by any resolution or other action. No such resolution or action shall be publicized unless it shall first have been approved by the House of Delegates, or by a majority of the Board when the House is not in session. No resolution adopted by any section shall be effective until likewise so approved.

Sec 5. Each section, except the two medical student special sections, shall elect a delegate and an alternate to the House of Delegates. The term shall be for two calendar years without limitation on number of terms.

Sec 6. There shall be two special sections for medical student members of the Society, one representing the University of Wisconsin and one representing the Medical College of Wisconsin, which shall each be entitled to elect one delegate and one alternate to the House of Delegates for each forty candidate members or majority fraction thereof in this Society determined as of the close of the calendar year preceding the first session of the House of Delegates Annual Meeting, provided, however, that these sections shall each be entitled to at least one delegate and one alternate. The term shall be for one calendar year without limitation on number of terms.

Sec 7. The specialty sections of the Society shall be considered an integral part of the working committee structure of the Society as outlined in Chapter VI of these Bylaws.

Chapter XII
Amendments

These Bylaws may be amended at any annual meeting by a majority vote of the delegates present, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one session of that annual meeting.

American Medical Association Principles of Medical Ethics

PREAMBLE: The Medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

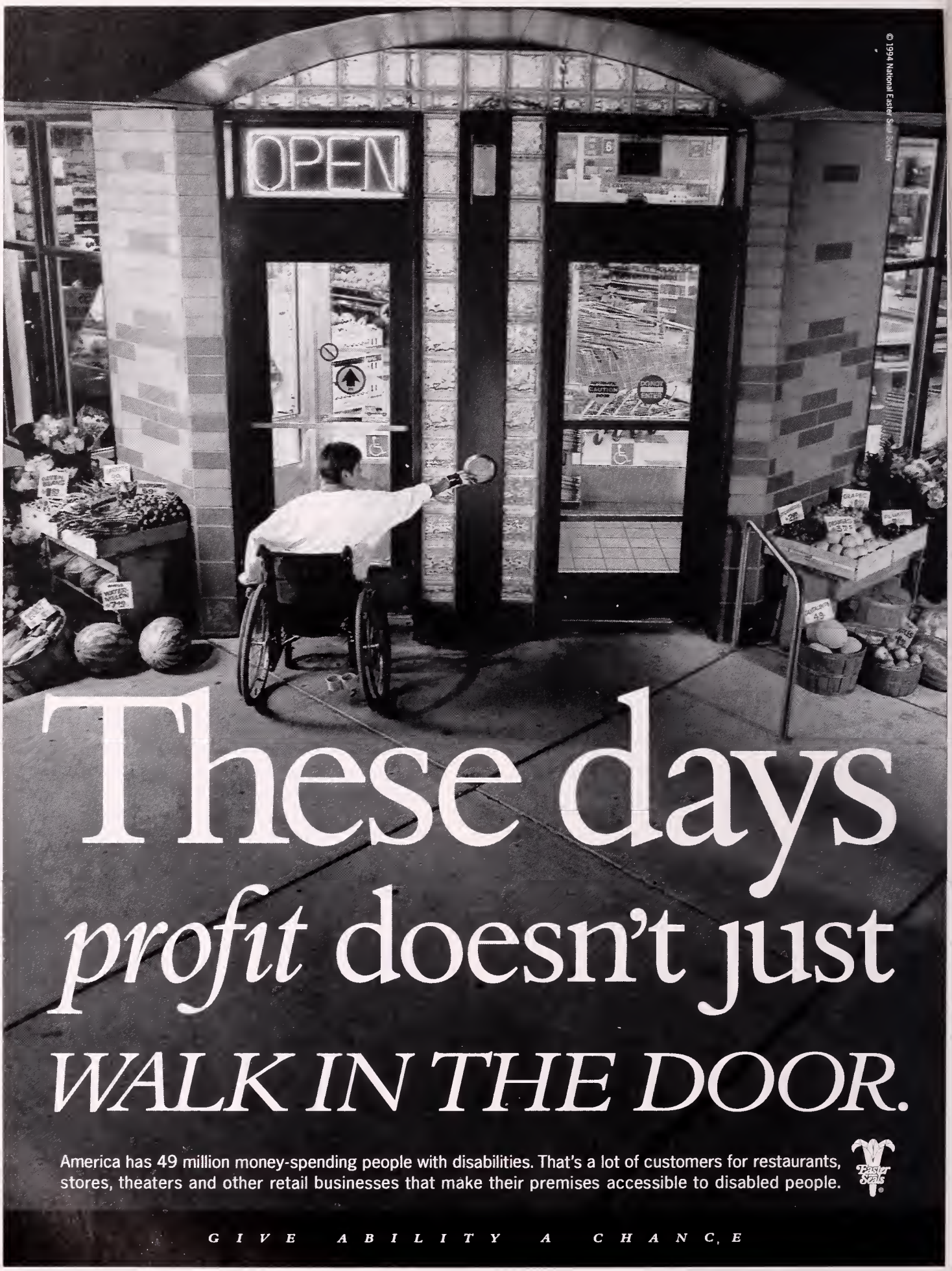
III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, of colleagues and of other health professionals, and shall safeguard patient confidences, within the constraints of the law.

V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.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Officers of Wisconsin's county medical societies

Key: president (P), president elect (PE), vice president (VP), secretary (S), treasurer (T), secretary-treasurer (ST), executive secretary (ES), executive vice president (EVP), executive director (ED).

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Continued on next page

Dr John E. Kraus, MD, is presented with the Meritorious Service Award with a hearty handshake from Dr Richard Ulmer, SMS' new president elect.

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Continued on next page

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715-369-7758

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Kaukauna 54130
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ES—Dolores Ebben
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Ozaukee
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4922 Colombia Rd
Cedarburg 53012
414-375-4430
ST--Scot A Wilfong, DO
1317 W Grand Ave
Port Washington 53074
414-284-6588

Pierce-St Croix
P—David M Wilhelm, MD
1687 Division St
River Falls 54022
715-425-6701
PE--Bruce G Hanson, MD
821 W Eighth St
New Richmond 54017
715-246-6911
ST—James Beix, MD
1687 Division St
River Falls 54022
715-425-6701

Polk
P—Carl W Hansen, MD
208 Adams St S
St Croix Falls 54024
715-483-3221
ST—Vacant

Portage
P—Joseph F Jarabek, MD
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Stevens Point 54481
715-344-4120
ST--John K Paulson, MD
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715-341-8044

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715-762-3212
ST--Joseph F Boero, MD
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715-762-3212

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414-634-6679
S—Carol W Potts, MD
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Richland Center 53581
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Baraboo 53913
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Galesville 54630
608-582-2286

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608-637-3195
VP—Jeffrey F Menn, MD
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Viroqua 54665
ST—Rolando A Macasaet, MD
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Viroqua 54665
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Lake Geneva 53147
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414-741-2298
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Elkhorn 53121
414-723-6666

Washington
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West Bend 53095
414-338-5321
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Milwaukee 53226
ST--Peter L Cornelius, MD
N168 W20060 Main St
Jackson 53037
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414-567-1499
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Waupaca 54981-1973
715-258-8898
ST—Donn D Fuhrmann, MD
1420 Algoma Street
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414-982-7240

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P—George W Arndt, MD
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Neenah 54956
ST—James E Cauley, MD
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Oshkosh 54901
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715-387-5351
VP--John W McDonough, DO
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715-421-5257
ST—Richard A Dart, MD
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Marshfield 54449-5777
715-387-5345 ❖

Officers of the SMS specialty and special sections

Key: chair (C), chair elect (CE), vice chair (VC), secretary (S), treasurer (T), secretary-treasurer (ST), delegate (D), alternate delegate (AD), AMA delegate (AMAD), AMA alternate delegate (AMA AD).

Allergy and Clinical Immunology
C—Marcus Cohen, MD
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VC--Marshall E Cusic, Jr, MD
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ST--John E Basich, MD
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Hales Corners 53130
414-425-5750
D—Donald A Bukstein, MD
1313 Fish Hatchery Rd
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608-252-8020
AD—Steven H Cohen, MD
5020 W Oklahoma Ave
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414-546-1110

Anesthesiology
C--Ashok R Krishnaney, MD
12016 W Verona Ct
West Allis 53227
ST—W Stuart Sykes, MD
1005 Columbia Rd
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608-263-8100
D—Edwin Lee Mathews, MD
8700 W Wisconsin Ave
Milwaukee 53226
414-257-6269
AD--J Alex Villacrez, MD
PO Box 518
Monroe 53566

Cardiology
C--Michael P Cinquegrani, MD
8700 W Wisconsin Ave
Milwuakee 53226
414-257-6073
D--Vacancy
AD--Vacancy

Cardiothoracic Surgery
C--Vacancy

Dermatology
C—William R Owen, MD
2727 Plaza Dr
Wausau 54401
715-847-3484
ST--Vacancy
D—Donald J Miech, MD
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Marshfield 54449
715-387-5311
AD—Stephen E Hoy, MD
324 E Wisconsin Ave #925
Milwaukee 53202
414-271-2721

Emergency Medicine
C—Peter Holzhauer, MD
15875 Ridgefield Ct
Brookfield 53005
414-769-4055
S--Thomas Luetzow, MD
N7406 County Trunk E
Watertown 53094
414-544-2267

D—Dean T Stueland, MD
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AD--Peter J Holzhauer, MD
15875 Ridgefield Ct
Brookfield 53005
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Family Physicians
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Ellsworth 54011
715-273-5061
ST--Lowell H Keppel, MD
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414-256-0006
D--George L Gay Jr, MD
AD-Thomas H Peterson, MD
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Wausau 54401

Group Practice
D--Philip J Dahlberg, MD
1836 South Ave
La Crosse 54601
608-782-7300
AD--Vacancy

Hospital Medical Staff
C—Edward R Winga, MD
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La Crosse 54601
608-782-7300
D—Paul A Wertsch, MD
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608-221-1501
AD--Masood Wasiullah, MD
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Internal Medicine
C--Daniel L Johnson, MD
2211 Stout Rd
Menomonie 54751
715-235-9671
CE--Gregory A Shove, MD
2405 Northwestern Ave
Racine 53404
414-635-6411

SMS board members and officers jumped to their feet to give a standing ovation to Richard Ulmer, MD, (seated) as he was honored for his nine years of service as chair of the SMS board. Shown applauding are: Dr Rich Roberts and Dr Ray Zastrow (who succeeds Ulmer as SMS board chair).

ST--John K Paulson, MD
2501 Main St
Stevens Point 54481-4026
715-344-4120
D--Vacancy
AD—Vacancy

International Medical Graduates
C--Kesavan Kutty, MD
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414-447-2245
VC--Miguel T Galang, Jr, MD
9008 W Burleigh St
Milwaukee 53222
414-871-4070
ST--Magbool Arshad, MD
3201 S 16th St
Milwaukee 53215
414-647-2326
D--Avadh B Agarwal, MD
4267 W Fond du Lac Ave
Milwaukee 53216
414-873-3440
AD--Juanito P Singson, MD
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Milwaukee 53207-6105
414-481-5881

Long-term Care
C--Michael Fehrer, MD
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Milwaukee 53222
414-445-5712
CE--Robert P Smith, MD
1313 W Seminary
Richland Center 53581
608-647-6161
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414-283-7300
D--Bruce A Kraus, MD
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Columbus 53925-0310
414-623-2323
AD--Richard S Kane, MD

Continued from preceding page

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C--Vacancy

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New Berlin 53151
C--Michael Hembd
7626 W Keefe Ave109
Milwaukee 53222
C--Peter Hoepfner
934 Robertson
Wauwatosa 53213
D--Vacancy
AD--Vacancy

Medical Students--UW
C--Tara Dall
2221 Post Rd #102
Madison 53713
C--Raymond J Kotwicki
3211 Stevens St #4
Madison 53704
D--Vacancy
AD--Vacancy

Neurology
C--Kevin H Ruggles, MD
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CE--Denis C Nathan, MD
2002 W Howard Ave
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D—Gamber F Tegtmeyer, Jr, MD
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Madison 53715
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AD--R Clarke Danforth, MD
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414-447-6030

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ST--Thomas Lyons, MD
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D--Mohammed Rafiullah, MD
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AD--Vacancy

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C—Robert J Jaeger, MD
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414-658-2133
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AD--Patricia A Barwig, MD
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Prairie du Sac 53578
608-643-2471
ST--Michael Major, MD
2350 W Villard Ave #111
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414-464-8880
D—James A Rydlewicz, MD
5233 W Morgan Ave
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AD—Thomas W Grossman, MD
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ST--Bradley K Beggs, MD
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D—Ronald R Martins, MD
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414-554-2285
AD—Raymond C Zastrow, MD
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414-527-8404

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414-291-1000
VC--Joanne A Selkurt, MD
1933 Park St
Whitehall 54773
D—Carl S L Eisenberg, MD
3003 W Good Hope Rd
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414-352-3100
AD--Vacancy

Physical Medicine and Rehabilitation
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PO Box 2901
Milwaukee 53201-2901
414-649-7706
VC and ST--Jerome Lerner, MD
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414-789-6884
D--Vacancy
AD--Vacancy

Plastic Surgery
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2015 E Newport #401
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414-263-1700
D—Andreas Doermann, MD

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C--Jane K Sliwinski, MD
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1414 E Washington Ave #227
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AD—Jane K Sliwinski, MD

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608-231-2600
T--Clarence Chou, MD
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414-257-7611
D--Kenneth I Robbins, MD
AD--Vacancy

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414-257-5636
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Waukesha 53188
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414-241-5040
D--Sally M Schlise, MD
916 S Monroe
Green Bay 54301
414-433-8184
AD—J Frank Wilson, MD

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D--Timothy T Flaherty, MD
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Neenah 54956
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414-649-7202
VC--Charles J Rainey, MD
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River Hills 53217
414-257-6023
D--Vacancy
AD--Vacancy

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715-356-3292
ST—Vacancy
D—James P Quenan, MD
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Shell Lake 54871
715-468-2711
AD—Rodney W Malinowski, MD
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Racine 53404
414-631-8011

Adam Balin, MD, of Oregon, rises to speak during debate in the 1995 House of Delegates. Dr Balin represents District 2 and practices in Madison.

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608-263-3035
ST--Vacancy
D--John P Schilling, MD
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608-252-8579
AD--Edward R Winga, MD
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La Crosse 54601
608-782-7300

Urology
C--Vacancy
D--Thomas W Wood, MD
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Continued on next page

Continued from preceding page
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CE--Adam H Balin, MD
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D--Edwin Overholt II, MD
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La Crosse 54601
608-782-7300
AD--Vacancy❖

Officers of Wisconsin specialty societies

Key: president (P), president elect (PE), vice president (VP), chair (C), vice chair (VC), secretary (S), treasurer (T), secretary-treasurer (ST), secretary-treasurer elect (STE), executive director (ED), executive secretary (ES), chapter administrator (CA).

Wisconsin Allergy Society
P--Marcus Cohen, MD
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VP--Marshall E Cusic, MD
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Marshfield 54449
715-387-5186
ST--John E Basich, MD
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Hales Corners 53130
414-425-5750

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P--Ashok R Krishnaney, MD
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West Allis 53227
ST—W Stuart Sykes, MD
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Wisconsin Chapter: American College of Cardiology
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Marshfield 54449-5777
715-387-5511
S--Charles Canver, MD
H4/352 UW CSC
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Madison 53792-3236
608-262-3858

Wisconsin Dermatology Society
P--William R Owen, MD
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Wausau 54401
715-847-3000
ST—Marcey Neuburg, MD
11352 N Bumtrock Ave
Mequon 53092

Wisconsin Chapter: American College of Emergency Physicians
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T--Mark Olsky, MD
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ED—Karen Teske-Osborne, MSN
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414-635-6411

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ED--Beth Bishop Perrigo
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414-276-6445
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Wisconsin Neurological Society
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715-387-5511
PE--Denis C Nathan, MD
2002 W Howard Ave
Milwaukee 53221
VP--Nancy Whipple Spencer, MD
2915 Colgate Road
Madison 53705
ST--Piero Antuono, MD
9200 W Wisconsin Ave
Wauwatosa 53226

Wisconsin Neurosurgical Society
ST--Thomas A Lyons, MD
900 E Grant St
Appleton 54911
414-749-9926

Wisconsin Section: American College of Obstetrics and Gynecology
P—Robert J Jaeger, MD
3291 Thompson Ct
Stevens Point 54481
715-344-4120
PE--Michael Schellpfeffer, MD
1400-75th St
Kenosha 53140
414-658-2133
ST--Frederick G Sehring, MD
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414-433-9000
ES--Robert Herzog
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ST—Frederick G Sehring, MD
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414-433-9000
ES--Robert Herzog
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Elm Grove 53122
414-784-3646

Wisconsin Academy of Ophthalmology
P—James Memmen, MD
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414-437-6505
PE--Kevin T Flaherty, MD
PO Box 689
Wausau 54401
715-845-8201
ST—Jack L Hughes, MD
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Milwaukee 53226
414-259-1930
ES—Robert H Herzog
850 Elm Grove Rd
Elm Grove 53122
414-797-7878

Wisconsin Orthopaedic Society
P—Paul A Jacobs, MD
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Milwaukee 53233
414-276-6000
VP—William R Niedermeier, MD
35 Prairie Ave #200
Prairie du Sac 53578
608-643-2471
ST--Michael R Major, MD
2350 W Villard Ave #111
Milwaukee 53209
414-464-8880

Wisconsin Society of Otolaryngology-Head and Neck Surgery
P--Thomas J Haberkamp, MD
9200 W Wisconsin Ave
Milwaukee 53226
414-454-5582

Sandra L. Osborn, of Madison, opens the SMS House of Delegates. This is Dr Osborn's second year as SMS speaker.

PE--Dennis E Feider, MD
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414-631-8210
ST—Glenn M Seager, MD
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Stoddard 54658
608-782-7300

Wisconsin Society of Pathologists
P--Gerald Hanson, MD
Dept of Pathology
8700 W Wisconsin Ave
Milwaukee 53226
414-257-6201
S—Bradley K Beggs, MD
1320 S Wisconsin Ave
Racine 53403
414-636-2212
T--Lloyd Arnold, MD
St Michaels Hospital
900 Illinois Ave
Stevens Point 54481
ED—Robert Herzog
850 Elm Grove Rd
Elm Grove 53122
414-797-7888

Continued on next page

University of Wisconsin music faculty provided an array of education and entertainment at the inaugural ceremony. Prior to embarking on her career in medicine, SMS President Marcia J.S. Richards, MD, majored in music.

Continued from preceding page

Pakistani Physicians Society of Wisconsin
P—Ayaz M Samadani, MD
148 Warren St
PO Box 678
Beaver Dam 53916
414-887-7731
ST--Vacancy

Wisconsin Chapter: American Academy of Pediatrics
P—Kathryn P Nichol, MD
2323 N Lake Dr
Milwaukee 53211
414-291-1000
VP--Joanne Selkurt, MD
1933 Park St
Whitehall 54773
ST—Karen Wendelberger, MD
9000 W Wisconsin Ave
PO Box 1997
Milwaukee 53201
414-266-3360
CA—Carolyn M Evenstad
4601 Wallace Ave
Monona 53716

Philippine Medical Association-Wisconsin
P—Maximo L Cueto, Jr, MD
2040 W Wisconsin Ave #754
Milwaukee 53233
S—Violeta A Singson, MD
2040 W Wisconsin Ave, #754
Milwaukee 53233
414-342-3080
S--Jessica Romero, MD
2040 W Wisconsin Ave #754
Milwaukee 53233
T—Teresita Lo, MD
2040 W Wisconsin Ave #754
Milwaukee 53233

Wisconsin Society of Physical Medicine and Rehabilitation
P—N M Reddy, MD
1000 N 92nd St
Wauwatosa 53226
414-259-1414
VP—Ephrem Thoppil, MD
2900 W Oklahoma Ave
PO Box 2901
Milwaukee 53201-2901
414-649-7706
ST--Jerome Lerner, MD
12630 W North Ave #E
Brookfield 53005
414-789-6884

Wisconsin Chapter: American College of Physicians
P—Mahendr S Kochar, MD
5000 W National Ave 14a
Milwaukee 53295
414-643-1530
VP--Frank Graziano, MD
600 Highland Ave
Madison 53792-0001
608-263-3457
S—Kenneth I Gold, MD
1905 Huebbe Parkway
Beloit 53511
608-364-2240
T—Kesavan Kutty, MD
5000 W Chambers St
Milwaukee 53210
414-447-2245

Wisconsin Society of Plastic Surgeons
P—Venkat K Rao, MD
600 Highland Ave
Madison 53792
608-263-1223
ST--Andreas Doermann, MD
2015 E Newport, #401
Milwaukee 53211
414-963-1700

Wisconsin Society for Preventive Medicine
P—Jane K Sliwinski, MD
1551 Dousman St
Green Bay 54301
414-496-4700

Wisconsin Psychiatric Association
P--Lucille Glicklich, MD
2000 W Kilbourn Ave
Milwaukee 53233
414-937-5492
PE--Kenneth Robbins, MD
301 Troy Drive
Madison 53704
608-243-2544
S--Jean Seay, MD
1531 S Madison #530
Appleton 54915
414-738-2727

T—Clarence Chou, MD
9501 Watertown Plank Rd
Wauwatosa 53226
414-257-7611
ES—Edward S Levin, Esq
PO Box 1109
Madison 53701-1109
608-283-5410

Wisconsin Council of Child and Adolescent Psychiatry
P--William J Swift Jr, MD
S—Edward S Orman, MD
130 E Walnut St
Green Bay 54301-4233
414-435-8816
T—Mary Pearlman, MD
236 Lakewood Blvd
Madison 53704

Wisconsin Society of Radiation Oncologists
P--J Frank Wilson, MD
8700 W Wisconsin Ave
Milwaukee 53226
414-257-5636
PE--Carl Olson, MD
2315 N Lake Dr
Milwaukee 53211
414-291-1075

S--Wingate F Clapper, MD
725 American Avenue
Waukesha 53188
414-544-2439
T--Mitchell H Pincus, MD
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414-241-5040

Wisconsin Radiological Society
P—Bernard Kampschroer, MD
N33 W23363 Greenbriar Ct
Pewaukee 53072
PE--Robert F Matzke, MD
PO Box 5003
Janesville 53547-5003
608-756-6743
ST--Thomas F Berns, MD
10534 N Country Club Dr 31W
Mequon 53092

Wisconsin Surgical Society
P--John R Pellett, MD
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600 Highland Ave
Madison 53792
608-263-6311
PE—Barry J Seidel, MD
PO Box 1390
Minocqua 54548
715-356-3292

ST--Eberhard A Mack, MD
H4/744 UW CSC
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Madison 53792
608-263-1387

Wisconsin Chapter: American College of Surgeons
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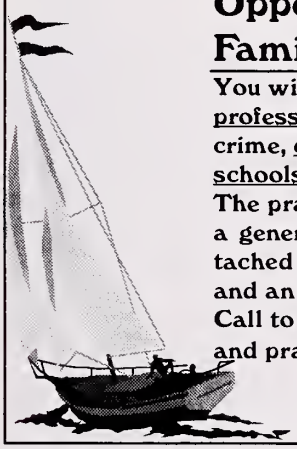
Madison 53704
608-241-4611
PE—William D Turnipseed, MD
H4/730 UW CSC
600 Highland Ave
Madison 53792
608-263-1388
VP—Mark Adams, MD
ST--Gregory Ekbom, MD
2300 N Mayfair Rd #895
Milwaukee 53226
414-453-2121

Wisconsin Urological Society
P—Barry H Usow, MD
2901 W KK River PKwy
Milwaukee 53215
414-672-6006
ST--Frank P Begun, MD
9200 W Wisconsin Ave
Milwaukee 53226
414-259-2795❖



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Marcia J. S. Richards, MD

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Armand Start, MD

Frank H. Urban, MD

Raymond C. Zastrow, MD

Cyril M. (Kim) Hetsko, MD

Statewide Physician Health Program

THE STATEWIDE PHYSICIAN Health Program (SPHP) provides compassionate assistance to Wisconsin physicians suffering from any condition which has the potential to progress to impairment. These conditions include chemical dependency, psychiatric illness, senility, compulsive gambling, behavioral disorders and physical impairment. The Statewide Program Managing Committee establishes policies and implements program activities. As a subcommittee of the Commission on Mediation and Peer Review, the Managing Committee and its activities are protected by way of confidentiality and immunity under state and federal law.

SPHP offers education, identification, assessment and compassionate intervention. Physicians who are intervened are referred to acceptable facilities for evaluation or treatment and monitored minimum two-year follow-up after completion of initial therapy. The SPHP Medical Director provides continuous program leadership, conducts physician interventions and is available to Wisconsin physicians and hospitals to offer counsel regarding local problems.

Any responsible person concerned that a physician may suffer from impairment may call the State Medical Society (608-257-6781 Madison or 1-800-362-9080 in Wisconsin). Strict confidentiality is assured. Staff assigned to receive information consult with the SPHP Medical Director for guidance and early action. All information, including corroborative evidence, is evaluated for accuracy. When it is determined that a potential problem exists, intervention is arranged with the involved physician.

Phase I: education and prevention

Target individuals and groups are educated to learn symptoms of physician impairment, techniques of early identification and prevention, resources available for intervention, assessment and/or treatment and other problems associated with impairment. The SPHP Medical Director and Associate Medical Director present educational and prevention programs to the following target groups:

- *Physicians:* Meetings of hospital medical staffs, county medical societies, statewide continuing medical education, accredited seminars and presentations to faculty and students in Wisconsin's medical schools.
- *Hospital Personnel:* Hospital administrators and medical directors, chiefs of medical staffs and others. Consultation with medical staff officers on establishing effective physician health committees or programs in hospitals. "Guidelines for Physician Aid Committees of Hospital Medical Staffs" have been distributed to all Wisconsin general hospitals with encouragement to implement them in cooperation with medical staffs.
- *Pharmacists and nurses:* Lectures at meetings or in combination with physician and hospital personnel.

Phase II: intervention, assessment and treatment

Successful programs include the availability of physician interveners to undertake compassionate contact with physicians identified as possibly impaired. The SPHP Medical Director or other trained physicians are available to meet with and urge impaired colleagues to enter suitable facilities for evaluation, treatment or both. Programs or facilities considered suitable are those which comply with Statewide Physician Health Program requirements.

The initial intervention is always a compassionate encounter. A punitive or coercive approach is never considered until all benevolent measures have been exhausted. An intervener's continuing concern is the professional and personal well-being of a colleague and the quality of health care for patients.

Physicians suffering from chemical dependency achieve a more satisfactory recovery status when they receive intensive treatment in facilities which espouse the medical model of therapy, under which the physician is seen by the physician addiction specialist on a frequent, if not daily basis. Within this model, SPHP maintains certain requirements for satisfactory primary treatment for chemical dependency.

Physicians suffering from emotional illness or senility, or from the sequelae of stress when these are uncomplicated by chemical dependency, are encouraged to seek assessment, treatment or both through Statewide Program approved facilities or practitioners.

SPHP adheres to the policy that satisfactory recovery can only be realized through a monitored two-year recovery period. It considers the two years after initial treatment to be vital to assuring continued recovery.

Phase III: benevolent assistance

In addition to the burden of impairment, some physicians are financially unable to pay the cost of the in-patient or out-patient care. By estimate, 10 percent of Wisconsin impaired physicians have either no or inadequate health insurance. The financial resources of some physicians essentially have been depleted. For 60 percent of chemically dependent physicians, residence in treatment and recovery homes (average of three months stay, at cost of $5,000 per month) is essential for completion of the two-year recovery program.

With SMS and CES Foundation Board approvals, SPHP established

a Physicians Benevolent Assistance Fund to provide low-interest loans to assist physicians to pay for in-patient and out-patient services. Loans are repayable after return to medical practice.

Phase IV: protecting the public
SPHP maintains formal linkage with the Wisconsin Medical Examining Board (MEB) through the Coordinating Council on Physician Impairment. Consisting of three SMS members and three MEB members, the Council coordinates activities so that appropriate information is shared and the Council can take action in the event a physician fails to respond to treatment or refuses to enter rehabilitation. By majority vote, the Council may refer a physician to the MEB in the rare instance where the health of the public may be jeopardized. The Coordinating Council presents a desirable balance of concerns and interest between the voluntary assistance program of the State Medical Society and the Wisconsin statutory licensing and disciplinary body. Thus, the Council is an appropriate step in the reporting process if necessary during attempts at physician rehabilitation where difficulty may be encountered. ❖

WISPAC and Physicians for Better Government

The Wisconsin Physicians Political Action Committee (WISPAC) is a voluntary, nonprofit organization open to physicians and their spouses. Restricted from making political contributions, the SMS created WISPAC to provide the medical profession an opportunity to become more politically active and effective. WISPAC is governed by a board of directors, traditionally concentrates on state legislative races, and cooperates with the American Medical Political Action Committee (AMPAC) on federal issues.

Physicians for Better Government is a direct giver program, or political conduit, established in 1987 by the SMS. Political conduits differ from political action committees in that contributors retain the right to decide who receives their individual contributions. Physicians for Better Government contributions are deposited in a special account in each contributor's name. No contribution is made to a candidate without the contributor's authorization.

WISPAC and Physicians for Better Government are administered by the SMS Government Relations, pursuant to state statutes and administrative rules authorizing and regulating these programs. For additional information, call 608-257-6781 or 1-800-362-9080.

Contributions may be sent to: Physicians for Better Government/ WISPAC, P.O. Box 2595, Madison, WI 53701.

Suggested membership categories include:

- $500 Chairman's Club
- $200 Sustaining Membership
- $100 Physicians for Better Government, $50 WISPAC, $50 AMPAC)
- $100 Sponsor
  ($50 Physicians for Better Government, $30 WISPAC, $20 AMPAC)

Contributions at the above levels authorize PFBG to transfer the amounts shown to WISPAC and AMPAC. If you wish to contribute differently, you may allocate amounts of your choice, per the examples below:

- $50 Physicians for Better Government
- $50 WISPAC/AMPAC ($30 WISPAC, $20 AMPAC)❖

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Call Marie Noeth at 800-438-3745 or fax your CV to 309-685-2574.

SMS physician support program

THE SMS COMMISSION on Medical Liability and Risk Management created the Physician Support Program in 1987 to help physicians and their families cope with the stress of being sued for malpractice. The program provides emotional support, practical information, and an opportunity for the physician and spouse to share their feelings with sympathetic listeners.

How the program works

When a physician is sued for medical malpractice, the SMS sends him or her a packet of materials that includes a letter explaining the Physician Support Program, advice on coping with the experience, and a list of physicians and spouses who have volunteered to serve as members of a special support group. The packet also contains a description of the Medical Mediation Panel System and helpful materials for the physician's spouse.

The Physician support group

The purpose of the support group is to offer emotional support and practical advice for dealing with a medical malpractice suit. The emphasis is on personal contact and communication between the physician or spouse requesting help and the panel member. The setting of meetings is left entirely to the parties involved, and may be limited to telephone calls, if desired. Topics covered during meetings are expected to be wide ranging, (eg feelings of hostility, fear, loss of confidence, difficulty in making decisions, and withdrawal from the family) but discussions of the specific merits of the case are avoided. The emphasis is on individual interaction and open and frank discussions. There are no group sessions. Confidentiality is assured in all cases.

Any practicing physician who has been a respondent in a malpractice action and feels he or she can offer emotional support to a colleague in a similar situation is encouraged to volunteer as a support group member. Spouses who can provide support for their counterparts are also invited to participate. Each panelist receives basic information about the program and advice on how to be an effective participant.

Physicians interested in providing peer support through the Physician Support Program should contact Anne Bicha at the SMS.❖

Letter to physician named in a medical mediation case

Items mentioned in this letter as "enclosed" are available from Anne Bicha at the SMS, 1-800-362-9080.

Dear Doctor:

According to our records, you have been named in a medical mediation case. Feelings such as anger, frustration and depression are common for physicians involved in a malpractice action. I am writing this letter to inform you that there are other physicians and spouses who have been through similar experiences and are willing to discuss those feelings.

As part of the work of the State Medical Society Commission on Medical Liability and Risk Management, we have looked at the effect of the medical malpractice action on the physician and his or her family. It was the recommendation of the Commission on Medical Liability and Risk Management to the Board of Directors that the State Medical Society establish a support structure for physicians and their families involved in professional liability actions. Part of our proposal recommended the establishment of a group of physicians and spouses who could serve as "sympathetic listeners" for the physicians and their families involved in a liability action.

I invite you and your spouse or significant other to utilize the program. The SMS Alliance strongly supported the creation of the support group since it would be very beneficial to family members. Enclosed is a list of physicians and spouses who have volunteered to serve. Please feel free to contact any individual on the list. He or she will assure you of maintaining confidentiality.

Also, enclosed is a brief description of the program for you and your spouse, or significant other, and helpful materials to cope with the stress associated with medical litigation. Remember, talking to an experienced, knowledgeable peer about your frustrations is important. If you have questions about the program, please feel free to contact Anne Bicha at SMS, 800-362-9080 or (608) 257-6781.

Sincerely,

Sidney E. Johnson, MD
Chair, Commission on Medical Liability and Risk Management

Mediation and peer review services

When misunderstandings arise about what the physician hopes to accomplish and what the patient expects, it is important that the patient discuss with the physician any questions about the medical care received. If they are not resolved, however, the SMS provides a means for resolving these differences.

The SMS Commission on Mediation and Peer Review receives, investigates, and resolves complaints and inquiries from patients and others, concerning Wisconsin physicians. The commission's standard of judgment is what constitutes good medical care. Physicians, too, may benefit from commission efforts to mediate differences between themselves.

Many complaints and questions received by SMS staff are resolved by telephone. By protocol, however, only written complaints will be considered by the commission. If all affected parties reside within the boundaries of a single county medical society, that society may assume jurisdiction of the complaint. If it does, the complaint will be transferred to the county medical society for investigation and resolution.

A protocol manual was developed by the Commission on Mediation and Peer Review and approved by the Board of Directors for conducting resolution of patient complaints, employing peer review mechanisms to test physician practice patterns, and responding to inquiries or requests for action regarding impaired physicians. The manual was designed to accommodate informal disposition of minor and uncomplicated complaints, as well as complex and serious matters which may involve due process, patient or physician appeals, proposed disciplinary actions, and Board of Directors consideration of a physician's SMS membership. The manual is available upon request.

Certain complaints received by the commission are evaluated by subcommittees, members of which submit reports and recommended resolutions to the commission chair. Frequently, these subcommittee conclusions are transmitted to the subject physicians, and as appropriate, to complainants. All subcommittee activities are reported to the commission. Matters of a more serious nature require additional use of the manual, as necessary.

The Commission on Mediation and Peer Review offers peer review services to private and governmental organizations and to physicians,

Continued on next page

AMA Trustee Timothy T. Flaherty, MD, of Neenah, gives an update on national health issues and discusses legislative initiatives.

Continued from preceding page
including utilization review, appropriateness of patient care, and quality assurance. Although it is empowered to initiate disciplinary action, the commission's most valuable peer review benefits have been educational, judging from physician's expressed appreciation for the commission's consultation in matters of proper patient care.

The commission maintains purview over the Statewide Physician Health Program and continues its interest in the Coordinating Council on Physician Impairment of the SMS and the Medical Examining Board. The commission participates in the Medicaid Medical Audit Committee, under contract between the SMS and the Wisconsin Department of Health and Social Services.

Commission members will also review cases submitted by physicians who are the subject of Medicare or Medicaid reviews, to provide an independent assessment of the appropriateness of care provided. In those instances where the commission disagrees with a WIPRO or other review organization finding, the commission will provide the physician with independent medical opinion in any further action taken by the review agencies.❖

HCFA 1500 Health Insurance Claim Forms can be ordered direct from SMS Holdings Corporation

Forms available include:

- **HCFA 1500 Health Insurance Claim Form**
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  Available in continuous form, or cut sheet for laser printers.
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  Disclosure statement for elective surgery of at least $500 (2 part carbonless).
- **B-1994 - Patient's Medicare Disclosure Form "B"**
  Disclosure statement for Medicare medically unnecessary denials (3 part carbonless)
- **SMSH 11-94 Return to Work/Physical Capabilities Report**
  Return to work form. (3 part carbonless)
- **Vaccine Immunization Statement**
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Accreditation program for continuing medical education

THE SMS'S ACCREDITATION program functions under the authority of the Accreditation Council for Continuing Medical Education (ACCME). Representatives from the American Board of Medical Specialties, American Medical Association, Association for Hospital Medical Education, Association of American Medical Colleges, American Hospital Association, Federation of State Medical Boards, and the Council of Medical Specialty Societies comprise the ACCME.

The SMS Commission on Continuing Medical Education currently reviews and accredits 55 hospitals, 18 specialty societies, two professional organizations, and two county medical societies in Wisconsin. Information is available from Kristin Bjurstrom Krueger, CMP, or Lisa Lawry at the SMS.

Category 1:
Category 1 CME designated by an accredited sponsor must meet the following requirements:

- be sponsored by an organization accredited for continuing medical education by one of the state medical associations or by the Accreditation Council for Continuing Medical Education (ACCME), and
- be designated as AMA PRA Category 1 education by that organization.

Category 1 activities can take the form of lectures, seminars, use of self-study materials, self-assessment programs, mini-residencies, and use of audio-visual or computer based materials, so long as they are designated as AMA PRA Category 1.

Category 2:
All Other CME Activities
Education reported under Category 2 must meet the definition of continuing medical education and fit one of the descriptions of education provided below. Category 2 activities must also comply with the AMA "Ethical Opinion on Gifts to Physicians."

Non-Supervised Personal Learning Activities

- Clinical consultations that contribute to a physician's education.
- Informal educational consultations about a patient can be reported; these hours should be estimated and reported in hour blocks.
- Participation in patient care review activities.
- Teaching of medical and other health care professionals.
- Patient centered discussions with colleagues.
- Journal club activities.
- Use of self-assessment examinations and reviews.

The following Wisconsin organizations were accredited by SMSW and ACCME for continuing medical education programming as of June 1, 1995

Accredited Hospitals
Appleton Medical Center and St Elizabeth Hospital, Appleton
Bellin Memorial Hospital, Green Bay
Beloit Memorial Hospital, Beloit
Berlin Memorial Hospital, Berlin
Children's Hospital of Wisconsin, Milwaukee
Columbia Hospital, Milwaukee
Community Memorial Hospital, Menomonee Falls
Fort Atkinson Memorial Hospital, Fort Atkinson
Gundersen Medical Foundation, Ltd and La Crosse Lutheran Hospital, La Crosse
Hartford Memorial Hospital, Hartford
Howard Young Medical Center, Woodruff
Kenosha Hospital and Medical Center, Kenosha
Lakeland Medical Center, Elkhorn
Langlade Memorial Hospital, Antigo
Luther Hospital, Eau Claire
Memorial Hospital of Iowa County, Dodgeville
Memorial Hospital at Oconomowoc, Oconomowoc
Mendota Mental Health Institute, Madison
Mercy Hospital, Janesville
Mercy Medical Center, Oshkosh
Meriter Hospital, Madison
Reedsburg Memorial Hospital, Reedsburg
Ripon Memorial Hospital, Ripon
Riverside Memorial Hospital, Waupaca
Sacred Heart Hospital, Eau Claire
Sacred Heart-St Mary's Hospital, Inc, Rhinelander
Sauk Prairie Memorial Hospital, Prairie du Sac
Shawano Community Hospital, Shawano
Sheboygan Memorial Medical Center, Sheboygan
Sinai Samaritan Medical Center, Milwaukee
St Agnes Hospital, Fond du Lac
St Clare Hospital, Baraboo
St Clare Hospital, Monroe
St Francis Hospital, Milwaukee
St Francis Medical Center, La Crosse
St Joseph's Community Hospital, West Bend
St Joseph's Hospital, Chippewa Falls
St Joseph's Hospital, Milwaukee
St Joseph's Hospital & Marshfield Clinic, Marshfield
St Luke's Hospital, Milwaukee
St Mary's Hospital, Green Bay
St Mary's Hospital, Milwaukee
St Marys Hospital Medical Center, Madison
St Mary's Hospital-Ozaukee, Mequon
St Michael Hospital, Milwaukee
St Michael's Hospital, Stevens Point
St Vincent Hospital, Green Bay

Stoughton Hospital Association, Stoughton
Theda Clark Regional Medical Center, Neenah
Veterans Administration Medical Center, Tomah
Watertown Memorial Hospital, Watertown
Waukesha Memorial Hospital, Waukesha
Wausau Hospital Center, Wausau
West Allis Memorial Hospital, West Allis
Winnebago Mental Health Institute, Winnebago

Accredited Specialties
American Cancer Society, Wisconsin Division
American Heart Association of Wisconsin
Fox Valley Academy of Medicine
Milwaukee Gynecological Society
Milwaukee Ophthalmological Society
Racine Academy of Medicine
Wisconsin Academy of Family Physicians
Wisconsin Allergy Society
Wisconsin Association for Perinatal Care
Wisconsin Neurological Society
Wisconsin Society of Anesthesiologists
Wisconsin Society of Obstetrics and Gynecology
Wisconsin Society of Otolaryngology—Head and Neck Surgery
Wisconsin Society of Pathologists
Wisconsin Society of Plastic Surgeons
Wisconsin Society of Radiation Oncologists
Wisconsin Surgical Society
Wisconsin Urological Society

Accredited County Medical Societies
Marinette-Florence County Medical Society
Pierce-St Croix County Medical Society

Other Accredited Organziations
Physicians Insurance Company of Wisconsin
Wisconsin Association of Medical Directors

ACCME Accredited
Medical College of Wisconsin
UW Center for Health Sciences
Interstate Postgraduate Medical Association
State Medical Society of Wisconsin❖

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A test program is being conducted which offers a bonus to eligible physicians who reside in certain geographic areas (Pennsylvania, West Virginia, Ohio, Michigan, Illinois, Indiana, Wisconsin, Minnesota and Iowa). You would receive a $10,000 bonus for each year you serve as an Army Reserve physician—for a maximum of three years.

You may serve near your home, at times convenient for you, or at Army medical facilities in the United States and abroad. There are also opportunities to attend conferences and participate in special training programs, such as the Advanced Trauma Life Support Course.

To learn more about the Army Reserve and the Bonus Test Program, call one of our experienced Medical Personnel Counselors:

Call Collect Maj. David Stokes - 414-771-5438

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Membership facts

Whether you are just starting medical school, engaged in postgraduate training, maintaining a full-time practice, or retired, the SMS has a membership classification to fit your needs. Election to membership by the county medical society in which your principal place of practice is located carries with it membership in the SMS and, if you wish, the American Medical Association. If you qualify for resident membership at the time of your election, your membership dues are greatly reduced. You may also qualify for reduced dues during the first two years of your practice. In addition, two-physician families may be eligible for a $50 discount on total SMS membership dues. Regular membership dues in 1996 are $665 for the SMS and $420 for the AMA; county society dues vary.

Dues for regular, part-time practice, or over-age-70 membership classifications may be paid in one lump sum or in two equal installments, with the first half due by Oct 1, 1995, and the second half by Jan 1, 1996.

An incentive plan is available for early payment of county and state dues: $25 off state dues for those regular members who pay state and county dues in full by Oct 1, 1995.

A more detailed list of SMS membership classifications and their corresponding dues follow.

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SMS Membership classifications

Regular: Member in active practice. Regular members who are in their first or second year out of residency, fellowship, or military obligation may qualify for reduced dues for the SMS, the AMA, or both.

Part-time practice: Physician, regardless of age, who practices 1,000 hours or less during the calendar year, but does not qualify for retired membership.

Resident: Member who as of Jan 1 of the dues year is in an approved training program as a hospital resident or research fellow and is licensed to practice medicine and surgery in Wisconsin.

Military service: Member who is serving in the US armed forces or US Public Health Service (generally not to exceed 5 years).

Associate: Member whose dues are waived because of financial hardship due to illness or disability. This classification is temporary and is reviewed on an annual basis.

Retired: Member who has completely retired from practice (works less than 240 hours each year). All dues are waived unless county society indicates it wishes to charge county dues. (Retired and life members who wish to receive Medigram and the *Wisconsin Medical Journal* must pay a $45 publications fee.)

Life: Member who has held membership in a state medical society for 50 years. Past presidents of the SMS are also included in this category.

Honorary: Physician named an honorary member by the Board of Directors for outstanding contributions to the medical profession.

Over age 70: Member in active practice who is over 70 years of age.

Scientific fellow: Person engaged in teaching or research in the basic sciences at an accredited college or university—but not holding a degree in medicine or osteopathy—by invitation and consent of the Board of Directors.

Emeritus: Retired member who has chosen not to renew his or her license, at the discretion of the Board.

Candidate: Member attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure.

Continued on next page

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1996 Dues

	SMS	*AMA*	*County*
Regular	$665	$420	Varies
First year in practice	$332	$210	Varies
Second year in practice	$498	$315	Varies
Two physician family	$615	$420	Varies
Part-time practice	$332	$420	Varies
Part-time over age 65	$332	$210	Varies
Resident	$ 85	$ 45	Varies
Military service	-0-	$280/$45	Varies
Associate	-0-	-0-	-0-
Retired	-0-	$ 84/-0-*	Varies
Life	-0-	$420/-0-*	-0-
Honorary	-0-	$420/-0-*	-0-
Over age 70	$332	$420/-0-*	Varies
Scientific Fellow	-0-	-0-	-0-
Emeritus	-0-	-0-	-0-
Candidate:			
Student	$ 10	$ 20	$2.50
Postgraduate-one	$ 10	$ 45	Varies

*Physicians in these categories may be eligible for exemption from AMA dues under the grandfather clause. (AMA dues-exempt members who were granted exemption before 1986 based on previously established criteria, with the exception of financial hardship or disability, will automatically be exempt from dues in 1986 and the years following.)

Current AMA policy provides for only two categories of exemptions: financial hardship or disability and 65 years of age or older and fully retired. AMA dues for under-age-65 and fully retired members may be reduced to $84.

State society dues are prorated on a monthly basis for those elected to membership July 1 through Aug 31. Those elected after Aug 31 are exempt from dues for the balance of the year in which they are elected. AMA dues are prorated on a semiannual basis.

To begin the membership process, contact your county medical society or call the Membership Department of the SMS at 1-800-362-9080 or 608-257-6781.❖

SMS resource directory

Timely, accurate information is essential in our complex, rapidly changing medical environment. Information—when you need it—on scientific issues, legislative issues, and socioeconomic issues is available from the SMS headquarters in Madison.

This SMS resource directory is provided as a brief reference guide to assist you in locating the resource person on the SMS staff who is best able to answer your questions on a wide variety of topics.

Simply call 1-800-362-9080 or (608) 257-6781 for immediate access to this valuable membership resource.

A

Accounting ..... Jim Esselman
Accreditation (CME) ..... Kristin Krueger/ Lisa Lawry
Addictive Diseases, Commission on ..... Anne Bicha/Karen Baier
Administrative rules ..... Colleen Wilson
Advance medical directives ..... Kalisa Barratt/ Colleen Wilson
Advertising, *Wisconsin Medical Journal* ..... Lynne Bjorgo
AIDS, Task Force on ..... Lynn Sherman/ Karen Baier
Alliance, SMS ..... Maria Van Cleve/Karen Butler
Allied health professionals ..... Kalisa Barratt
Alternative delivery systems ..... Kalisa Barratt/ Kevin Wymore
AMA Delegation ..... Tom Adams/ Margaret Wiersum
Americans with Disabilities Act ..... Kalisa Barratt
AMPAC ..... Mike Kirby
Annual meeting ..... Kristin Krueger
Antitrust ..... Mark Adams

B

Beaumont 500 Club ..... Julie Hein
Bequests ..... Julie Hein
Board of Directors ..... Tom Adams/ Margaret Wiersum
Bylaws: CMS, hospital medical staff ..... Kalisa Barratt

C

Candidate interviews ..... Field representatives
Capitol Update ..... Mike Kirby
Chiropractic ..... Colleen Wilson
CHILD SAFE ..... Lynn Sherman/ Field representatives
Charitable, Educational & Scientific Foundation (CESF) ..... Julie Hein
Claim forms (HCFA) ..... Bill Guerten
Clinical Laboratory Improvement Act (CLIA '88) ..... Kalisa Barratt/Tamara Larson
CME, accreditation ..... Kristin Krueger/ Lisa Lawry
Coding ..... Jan Rasmussen
Confidentiality ..... Kalisa Barratt/Sonia Porter
Commissions, appointments and reappointments ..... Cheryl McCollum
Communications ..... Shari Hamilton
Complaints about medical care ..... Sonia Porter/ Anne Bicha
Computers ..... Doug Turecek
Congress ..... Mike Kirby
Consent and related issues ..... Kalisa Barratt
Continuing Medical Education, Commission on ..... Kristin Krueger/ Lisa Lawry
Contract review ..... Kalisa Barratt
Copy center and printshop ..... Dave Conner
Cost containment ..... Kevin Wymore
County medical society outreach ..... Field representatives

D

Desktop publishing ..... Vicki Meyer
Domestic violence ..... Shari Hamilton/ Lynn Sherman

E

Economic credentialing ..... Kalisa Barratt/ Anne Bicha
Elderly issues ..... Lynn Sherman
Emergency medical services (EMS) ..... Lynn Sherman
Endorsed programs ..... Noreen Krueger/ Lee Johnson
Endowment Funds ..... Julie Hein
Environmental and Occupational Health Commission ..... Lynn Sherman/ Karen Baier
Ethical opinions ..... Kalisa Barratt
Ethics and medicine ..... Maria Van Cleve
Executive Committee ..... Tom Adams/ Margaret Wiersum

F

Facilities manager ..... Don Temby
Farm safety ..... Lynn Sherman
Federal legislation ..... Mike Kirby
Federal Register review ..... All policy analysts
Fifty-Year Club ..... Lisa Lawry
Field representatives ..... Maureen O'Brien, James Reuter, James Schleck, Steve Whittow
Finance Committee ..... Jim Esselman/ Sally Frankey
Fort Crawford-Museum of Medical Progress ..... Julie Hein
Fraud and abuse—safe harbors, physician self-referral ..... Kalisa Barratt/Anne Bicha

G

Gambling addiction ..... Anne Bicha
Geriatric Health, Commission on ..... Lynn Sherman/Merry Earll
Golf Classic (CESF) ..... Julie Hein
Governmental Affairs, Commission on ..... Mike Kirby/Judy Frey
Group practice ..... Kevin Wymore
Group Practice Section ..... Cheryl McCollum
Gun violence and safety ..... Lynn Sherman

H

HCFA (claim) forms sales ..... Bill Guerten
Health care economics ..... Kevin Wymore
Health Care Financing and Delivery, Commission on ..... Kevin Wymore/ Merry Earll
Health Care Information, Office of (OHCI) ..... Anne Bicha
Health care rationing ..... Anne Bicha
Health care reform ..... Colleen Wilson
Health insurance ..... Anne Bicha/Lynn Sherman/ Kevin Wymore
Health law ..... Mark Adams/Kalisa Barratt
Health maintenance organizations (HMOs) ..... Kevin Wymore/Anne Bicha
Health professional shortage areas (HPSAs) ..... Anne Bicha
Hepatitis B vaccinations ..... Kevin Wymore
Home health care ..... Lynn Sherman
Hospice care ..... Lynn Sherman
Hospitals—regulation, accreditation, privileges ..... Kalisa Barratt
Hospital Medical Staff Section ..... Anne Bicha
House of Delegates ..... Tom Adams
Human Resources ..... Barb Kopenski/ Jane Wright

Impaired physicians ..... Sonia Porter/ John LaBissoniere
Individual practice associations (IPAs) ..... Kalisa Barratt/Kevin Wymore
Information systems ..... Doug Turecek
Injury Prevention and Control, Commission on ..... Lynn Sherman/ Karen Baier
Insurance, Office of the Commissioner of ..... Anne Bicha
Insurance plans ..... see SMS Insurance Services
Integrated delivery services ..... Kevin Wymore
International Medical Graduates Section ..... Anne Bicha
Interprofessional code ..... Mark Adams

J
Joint Commission on Accreditation of Health Care Organizations ..... Kalisa Barratt/ Anne Bicha

K
Key contact system ..... Mike Kirby

L
Label requests and sales ..... Joyce Pease/ Jim Sartori
Lakedge Printing ..... Dave Conner
Lakeside Association Services, Inc. (LASI) ..... James Hoegemeier
Legal counsel ..... Mark Adams/Kalisa Barratt
Legislation ..... Mike Kirby
Kathy Andersen
Colleen Wilson
Legislative Directory ..... Judy Frey
Legislative issues booklet ..... Mike Kirby
Liability insurance regulations ..... Mark Adams/ Anne Bicha
Licensure ..... Kalisa Barratt/Colleen Wilson
Living wills ..... Kalisa Barratt/Colleen Wilson
Lobbying ..... Mike Kirby
Kathy Andersen
Colleen Wilson

M
Mailroom ..... Dave Conner
Managed care ..... Mark Adams/ Kevin Wymore/Anne Bicha
Maternal and Child Health, Commission on ..... Kevin Wymore/Karen Baier
Media relations ..... Shari Hamilton
Mediation and Peer Review, Commission on ..... Anne Bicha/Sonia Porter
Mediation panels ..... Mark Adams/Anne Bicha
Medicaid (Title 19) ..... Kevin Wymore
Medicaid Medical Audit Committee ..... John LaBissoniere/Sonia Porter
Medical Assistance Technical Advisory Committee ..... Kevin Wymore/Merry Earll
Medical Business Specialist Certificate Program ..... Karen Garrett
Medical Examining Board (MEB) ... Colleen Wilson
Medical liability ..... Mark Adams/Anne Bicha
Medical Liability and Risk Management, Commission on ..... Anne Bicha/Karen Baier
Medical outcomes research project ..... Sally Wencel/Peter Alles/Lynne Thomas
Medical records ..... Kalisa Barratt/Sonia Porter
Medical residents ..... Anne Rittman
Medical service organizations ..... Kevin Wymore/ Kalisa Barratt
Medical Student Section ..... Anne Rittman
Medical Times ..... Shari Hamilton
Medicare audits ..... Tamara Larson
Medicare (Title 18) ..... Anne Bicha/Tamara Larson
Medicare coding ..... Tamara Larson
Medicine and Ethics, Commission on ..... Maria Van Cleve/Karen Butler
Medigram ..... Shari Hamilton
Meeting planning ..... Kristin Krueger
Membership ..... Anne Rittman
Joyce Pease
Michelle Kniess
Milwaukee office ..... Mary Thompson
Memorial giving program (CESF) ..... Julie Hein
Mini internship program ..... Field representatives
MinnesotaCare ..... Mark Adams
Museum, Fort Crawford Medical ..... Julie Hein

N
National Practitioner Data Bank ..... Kalisa Barratt/ Anne Bicha
Nominating Committee ..... Margaret Wiersum

O
Occupational health ..... Lynn Sherman
Occupational Safety and Health Act (OSHA) Blood-borne Pathogen Standards ..... Lynn Sherman/Kalisa Barratt
Occupational Health Guide ..... Julie Hein/ Lynn Sherman
Office of Health Care Information (OHCI) ..... Anne Bicha
Optometry ..... Colleen Wilson
Organ transplants ..... Maria Van Cleve
Outcomes management .... Sally Wencel/Peter Alles

P
PartnerCare ..... Tamara Larson

Patients Compensation Fund (PCF) ..... Mark Adams/Anne Bicha
Peer review ..... Anne Bicha
Pharmacy ..... Colleen Wilson
Physician Health Program, Statewide ..... John LaBissonaire/Sonia Porter
Physician hospital organization (PHO) ..... Mark Adams
Physician income statistics ..... Mark Adams/ Anne Rittman
Physician organizations (PO) ..... Mark Adams
Physician profiling ..... Kalisa Barratt
Physician support program ..... Anne Bicha/ Karen Baier
Physicians for Better Government (PFBG) ..... Mike Kirby/Bruce Hesse
Physician's Guide to Wisconsin Health Law ..... Kalisa Barratt
Orders ..... Lynne Bjorgo
Political action ..... Mike Kirby
Policy compendium ..... Maria Van Cleve
Pooled income fund ..... Julie Hein
Power of attorney for health care ..... Kalisa Barratt/Colleen Wilson
Practice guidelines ..... Sally Wencel/Peter Alles
Practice management seminars ..... Karen Garrett
Practice parameters ..... Anne Bicha
Preferred provider organizations (PPOs) ..... Kalisa Barratt/Kevin Wymore
Primary Care Consortium ..... Lynn Sherman
Professional review organizations (PROs) ..... Anne Bicha
Public health ..... Policy analysts
Public Information, Commission on .. Lynne Bjorgo

Q

Quality Assessment/Practice Parameters, Task Force on ..... Sally Wencel
Quality Compliance, Bureau of ..... Lynn Sherman
Quality of care reviews ..... Anne Bicha

R

Regulation & Licensing, Department of (DRL) ..... Colleen Wilson
Report cards (physician profiles) ..... Sally Wencel/ Peter Alles
Resident Section ..... Anne Rittman
Resource Based Relative Value Scale (RBRVS) ..... Tamara Larson/Anne Bicha
Risk management ..... Mark Adams/Anne Bicha
Rural health ..... Anne Bicha/Mike Kirby

S

Safe transportation ..... Lynn Sherman
SCAN ..... Maria Van Cleve
School health ..... Kevin Wymore
Scope of practice ..... Kalisa Barratt/Colleen Wilson
Scholarship program (CESF) ..... Jane Anderson
Scientific Medical Education Program ..... Kristin Krueger/Lisa Lawry
Seminars program ..... Karen Garrett
Senior Physicians, Wisconsin Association of ..... Julie Hein
SMS Holdings ..... Lee Johnson
SMS Insurance Services, Inc. ..... Mike Dolan
Speakers bureau ..... Field Representatives
Specialty sections and societies ..... Michelle Kniess
Speech writing (officers) ..... Shari Hamilton
Strategic plan ..... Tom Adams
Student loan program (CESF) ..... Jane Anderson

T

Third-party payors ..... Mark Adams/ Kevin Wymore
Tobacco and health ..... Lynn Sherman/ Shari Hamilton
Tobacco Free Wisconsin Coalition Lynn Sherman/Kathy Andersen/Shari Hamilton
Tort reform ..... Mark Adams/ Anne Bicha

U

Usual, customary and reasonable fees (UCR) ..... Anne Bicha/Kevin Wymore
Utilization review ..... Kalisa Barratt

W

WHCLIP/PCF Board of Governors .... Mark Adams
WIPRO ..... Anne Bicha
Wisconsin Administrative Code ..... Colleen Wilson
Wisconsin Medical Journal ..... Shari Hamilton
Wisconsin Medical Outcomes Research Network (WMORN) ..... Sally Wencel
Wisconsin Health Care Liability Insurance Plan (WHCLIP) ..... Mark Adams
WISPAC ..... Mike Kirby/Bruce Hesse
WNA-SMS Liaison, Commission on ..... Anne Bicha/Karen Baier
Worker's Compensation ..... Mark Adams/ Mike Kirby/Lynn Sherman
Workshop on Health ..... Maria Van Cleve
WPS Medicare ..... Tamara Larson/Anne Bicha

Y

Young Physicians Section (YPS) ..... Anne Rittman

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P.O. Box 962, Fond du Lac 54936-0962

Kevin F Quinn, MD (1995/1995-1998)
1147 Glenayre, Neenah 54956

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PO Box 574, Green Bay 54305

Anthony R Mars, MD (1995/1995-1998)
807 Barbara Ln, Marinette 54143

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Douglas M DeLong, MD (1995/1995-1998)
906 College Ave W, Ladysmith 54848

District 8
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69 N 28th St, Superior 54880

Ex officio, without vote
Executive Vice President & Secretary Adams
Medical Student, UW-Madison
Michael Bigelow, Medical Student,
Medical College of Wisconsin

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8430 W Capitol Dr, Milwaukee 53222
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1000 North Oak Ave, Marshfield 54449
Kenneth M Viste, Jr, MD (1993/1996 & 1997)
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1112 Charles Dr, Tomah 54660
Robert F Purtell, Jr, MD (1991/1995 & 1996)
3316 W Wisconsin Ave, Milwaukee 53208
Kevin T Flaherty, MD (1994/1996 & 1997))
PO Box 689, 614 First St, Wausau 54402-0689
Robert J Jaeger, MD (1995/1995, 1996 & 1997)
3291 Thompson Court, Stevens Point 54481

Paul J Leehey, III, MD (1995/1995, 1996 & 1997)
1836 South Ave, La Crosse 54601

Young Physicians Section Delegates to the AMA
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800 W Avenue South, La Crosse 54601
Evan K Saunders, MD (1995)
2901 W KK River Pkwy, #160, Milwaukee 53115

YPS Alternate Delegates to the AMA
Spencer J. Block, MD (1995)
1244 Wisconsin Ave, Suite 300, Racine 53403
Adam H. Balin, MD (1995)
753 North Main St, Oregon 53575

NOTE: Officers, directors, delegates, alternate delegates, and members of commissions are elected at the Annual Meeting (April 1995). Dates in parentheses indicate initial year of appointment and beginning and expiration of terms of office. AMA delegates and alternate delegates' terms of office are on a calendar basis, although elected at the Annual Meeting.❖

Publications available

A NUMBER OF BROCHURES are available from the SMS. Most are intended as patient-education materials on scientific and socioeconomic issues; others are useful as physician-education tools on socioeconomic and legislative topics. Some are available free of charge, while others require a nominal charge. State and local sales tax (5.5%) will be added. Call the SMS Division of Communications for more information (unless indicated otherwise): 1-800-362-9080, or in Madison, 257-6781.

Advanced CPT-4 Coding
This manual is intended for experienced coders and includes an intense series of advanced coding exercises designed to fine-tune coding skills. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

Advanced ICD-9 CM Coding
This manual is designed for experienced coders. It will reinforce coding guidelines and sharpen ICD-9-CM coding skills to provide the highest quality diagnostic information needed to enhance reimbursement. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

Anatomy and Physiology
This manual reviews the basics of body structure and function including both normal and pathological conditions. It provides a basic understanding of problems commonly encountered in health care settings and, combined with medical terminology, provides the foundation needed for accurate reimbursement coding and medical chart entries. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

Basic CPT-4 Coding
This basic manual is designed for beginning coders. It stresses the rules and guidelines of the CPT-4 book. There are beginning level exercises stressing the fundamentals. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

Basic ICD-9 CM Coding
This basic manual is designed for beginning coders. It stresses the importance of the ICD-9-CM system and introduces the guidelines necessary to use the system correctly. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

Cardiovascular Coding for Physician Reimbursement
This manual is designed for advanced coders and addresses advanced level issues in both CPT-4 and ICD-9-CM unique to cardiovascular coding. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

CPT-4 Evaluation and Management Coding
This manual is designed to help coders understand the CPT-4 Evaluation and Management (E/M) codes. The manual contains exercises to stress the necessary information needed to use the E/M codes correctly. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

Customer Service Enhancement for The 90's
This manual is designed to prepare you for the fast-paced 90's and teach you skills to keep patients coming back. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

Facts About Malignant Melanoma
This patient education brochure explains who is most at risk, how to detect and prevent melanoma, and how to conduct a self-examination. Published in 1988. Contact Lynn Sherman.

Lead Poisoning
Developed and published by the US Environmental Protection Agency, the brochure "Lead Poisoning and Your Children" provides easy to read patient information on how to reduce the risk of lead poisoning. Published in 1992. Contact Lynn Sherman.

Tuberculosis
"The Core Curriculum on Tuberculosis: What the Clinician Should Know" was developed by the US Department of Health and Social Services and the CDC to assist physicians in all aspects of TB control. The guide provides information on screening for TB, infection control, diagnosis and preventive therapy.

Smoking
The National Cancer Institute's Manual for Physicians, entitled "How to Help Your Patients Stop Smoking" is a comprehensive guide of tips and facts for decreasing your patient's use of tobacco products. Materials on how to develop a patient smoking cessation program, creating a smoke-free office and easy-to-use tear-outs are included. Contact Lynn Sherman.

General Surgery Coding for Physician Reimbursement
This specialty manual is designed for advanced coders and provides instruction in general surgical coding including the importance of accurate CPT-4 and ICD-9-CM coding for optimal surgical reimbursement. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

Health Insurance 101
This handbook is designed to introduce the basics of the health insurance industry. Emphasis is placed on basic health insurance terminology, benefit interpretation, types of contracts and resolving claim problems. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

If You Have a Complaint About Medical Care
This brochure explains the SMS's grievance and peer review system. Published in 1983. Contact Sonia Porter.

Intermediate CPT-4 Coding
This manual is designed for coders with a minimum of six months coding experience. It reviews the fundamentals and challenges the coder with a series of intermediate level problem-solving exercises to expand coding skills. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

Intermediate ICD-9 CM Coding
The intermediate ICD-9-CM manual is designed for coders with a minimum of six months coding experience. It reviews the basic fundamentals of the ICD-9-CM coding system and focuses on the ICD-9-CM rules through a series of challenging exercises. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

Legal Guidelines for Health Care Records
This manual is designed for medical group managers and office personnel and covers all aspects of medical records management. $25.00 + tax. Contact Elaine Stern, SMS Seminars

Office and Reception Skills
This handbook is designed for front office personnel. It gives instruction on scheduling appointments, telephone etiquette, reception skills and interaction with patients. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

Medical Professional Liability Insurance: Claims Made or Occurrence?
This brochure explains for physicians how the policies work, how premiums are established, how coverage is terminated, the limits of liability and how to decide between the types of coverage. The brochure was produced by the SMS Young Physicians Section and is particularly useful for physicians just beginning their practice. Revised in 1992. Contact: Alice Ballweg at 1-800-545-0631, or in Madison, 283-5483.

Medical Terminology
This manual is designed to introduce basic medical terminology. There is an emphasis on terms commonly used for insurance claims and coding. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

Medicare Part B Physician Reference Manual
This guidebook is designed to help the physician's billing staff stay on top of Medicare's policy and procedures. $49.00 + tax. Contact Elaine Stern, SMS Seminars.

OB/GYN Coding for Physician Reimbursement
This manual is designed for advanced coders and addresses issues in both CPT-4 and ICD 9-CM coding encountered in the OB/GYN practice. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

Occupational Health Guide
This revised edition contains information for medical and nursing personnel in the commercial and industrial setting. Entitled "Your Body At Work" the guide includes information on medical directives, planning for medical emergency care, OSHA Bloodborne Pathogen Standards and universal precautions for transmission of HIV infection and tuberculosis. A supplement with material on the "Americans With Disabilities Act" and other pertinent informa-

tion will be available in the fall of 1995. Contact Jane Anderson, CES Foundation.

PartnerCare
A poster and brochure aimed at educating elderly low-income patients about this important SMS voluntary Medicare assignment program. Contact Tamara Larson.

A Physician's Guide to Wisconsin Health Law
This handbook deals with the more important legal and socioeconomic issues affecting the practice of medicine in Wisconsin. The information in this book will help you avoid pitfalls, answer your patients' questions, ask the right questions when you need counsel, and become a more involved and effective voice for the profession. A revised version will be available in the fall of 1995. Contact Lynne Bjorgo, SMS Communications.

A Practical Guide to Public Relations
This booklet is designed to assist Wisconsin's county medical societies enhance their public relations efforts in their own communities. Published in 1988. Contact Lynne Bjorgo, SMS Communications.

Questions and Answers on Smokeless Tobacco
This patient education brochure explains smokeless tobacco and its dangers in very plain language. Published in 1988. Contact Lynn Sherman.

UCR, A Patient's Guide: How Much Will My Health Insurance Pay?
This brochure explains what "usual, customary and reasonable" means, how misunderstandings concerning it can be avoided and how problems can be resolved when they occur. This brochure is suitable for enclosure in office statements or for placement in patient reception areas. Revised in 1994. Contact Lynne Bjorgo, SMS Communications.

Vaccine Information
The new "Vaccine for Children" (VFC) program, which started October 1, 1994, requires all public and private health care providers to use the new patient-friendly information statements. When administering DTP, Td, MMR, DTaP, DT, DTP/Hib combinations and polio, these information statements are required. These forms are available from SMS Holdings by contacting Bill Guerten at 800-545-0632. The price is $25 for 100 sets of 4 forms.

Worker's Compensation
The SMS makes available to physicians several brochures and forms designed to ease the burden of worker's compensation cases. "The Guide for Wisconsin Doctors: Using the WC-16B for Worker's Compensation" published in 1986 and the booklet "How to Evaluate Permanent Disability," published in 1995, are available. The "Return to Work/Physical Capabilities" form, produced by the SMS Commission on Occupational and Environmental Health , is available. This revised form was developed to be comprehensive and user friendly for employers, physicians and patients.

Your Right to Direct Your Future Health Care
Facing questions on advance directives? The SMS now has pamphlets for patients explaining advance directives and medical treatment decision making. This easy-to-read, non-technical pamphlet will help you respond to the anticipated increase in patient questions about these issues as the result of a new law. As of Dec. 1, 1991, all federally-certified nursing homes, hospitals, home health agencies, hospices, personal care agencies, and health maintenance organizations are required under the federal Patient Self-Determination Act to provide written information to patients describing their rights regarding self-determination of medical care. As a result, many patients will be looking to their doctors for information. This brochure was developed by the Wisconsin Division of Health in cooperation with the SMS and other organizations. Published in 1991. Contact Lynne Bjorgo, SMS Communications. ❖

County medical society news

Brown. The Brown County Medical Society met in Green Bay at the Holiday Inn-City Centre, on May 11, 1995. Michael Sluss, MD, and Per Anderas, MD spoke about medical care in Central Africa. Steven Stroman, MD and Gregory Schmunk, MD, were approved for membership.

Dane. The Dane County Medical Society approved membership for the following physicians: Gregory Bills, MD; Sandra Herbage, MD; Diana Lardy, MD; Ann Mulkerin, MD; and Visilla Young, MD.

Green. The Green County Medical Society met on May 9, 1995. Dr John Wolff, UW Medical School, spoke on the current status of genetic engineering. Physicians approved for membership include: Igor Levin, MD; Rebecca Zinck, MD; Michael Netzel, MD; David Ruf, MD; and David Lippie, MD.

La Crosse. The following physicians were elected to membership in the La Crosse County Medical Society: Todd A. Mahr, MD; and Robert J. Freedland, MD.

Milwaukee. The Medical Society of Milwaukee County approved membership for the following physicians: Margaret Herzog Carr, MD; Marc F. Catalano, MD; Michael J. Dunn, MD; Jung Y. Hahr, MD; Dennis E. Schultz, Jr, MD; Santiago T. Sy, MD; Walter Khe Tian Wong, MD; Zia Agha, MD; Agnes O. Bilog, MD; Michele M. Eich, MD; Amy Jo Nopper, MD; Timothy J. O'Brien, MD; Vani Ray, MD; and Maria Teresita De La Paz Rivera, MD.

Monroe. The Monroe County Medical Society approved membership for Rolando R. Buan, MD.

Portage. The Portage County Medical Society approved membership for Steve Bergin, MD.

Rock. The following physicians have been approved for membership in the Rock County Medical Society: Edward P. Callahan, MD; David M. Fantle, MD; Suresh Kumar Madan, MD; Scott E. Miller, MD; Narumi O'Hara, MD; Jimson C. Tse, MD; Steven N. Schroeder, MD; and William Peter West, MD.

Sheboygan. The Sheboygan County Medical Society approved membership for Robert Molina, MD.

Wood. The Wood County Medical Society met on April 20, 1995 at Palomino's in Marshfield. Physicians approved for membership include: Brian Goldstein, MD; Yasmin Hussain, MD; Kathleen Meyer, MD; Thancoung Ngyuyen, MD; Theresa Perrone, MD; Kathryn Pyzdrowski, MD; Gurinder Sandu, MD; Jeanne Spellman, MD; and Victoria Viegut, MD.❖

Physicians Insurance Company of Wisconsin: State of the Corporation

In March of 1994, the PIC Wisconsin Board of Directors ratified a two-year strategic plan. This strategy allowed us to aggressively seek new business opportunities and respond rapidly and effectively to emerging developments in the ever-changing health care marketplace. This has resulted in the design of creative new products and services, investments in the latest advanced technology, increased public relations efforts enhancing our visibility in new markets, and a renewed commitment to the team concept within our organization.

Fiscal Highlights

Financially, 1994 was our most successful year ever. Consolidated net income grew to $5.7 million versus $3.8 million in 1993. Group assets exceeded $125 million at year end. We responded to shareholders' concerns about the liquidity of their shares by redeeming 2,480 shares of Class A common stock as part of our shareholder liquidity plan.

In 1994, AM Best rated our company B++ (very good), a laudable designation for a company only eight years old. AM Best affirmed our B++ rating in 1995. We will attempt to improve our rating this fall when AM Best reviews our financial position.

PIC Wisconsin concluded the year with nearly 4,200 physician

Continued on next page

Physicians Insurance Company of Wisconsin, Inc. and Subsidiaries		
	12/31/94	**12/31/93**
Total assets	$125,146,115	$127,929,822
Reserves for losses and loss adjustment expenses	85,387,721	81,829,054
Stockholders' equity	23,798,115	28,921,923
For the year ended December 31	**1994**	**1993**
Premiums earned	$25,464,787	$28,631,133
Net income	5,729,445	3,787,424

Continued from preceding page
insureds. This number represents nearly 150 more physicians than the year before despite severe competition.

Our dental market insureds increased to 378 in 1994, including nearly 100 dentists of the Nevada Dental Association. The Member Benefit Program we developed exclusively at the NDA's request in 1993 has been gaining momentum, and has served as a prototype for additional programs we have designed specifically to suit the needs of other insureds.

The past 12 months proved to be a successful year for our fledgling hospital program. By the end of December, PIC Wisconsin had written four hospitals. In January 1995, we gained two more, bringing our total hospitals to six.

Sharing Positive Results with Insureds

Our positive operating results have translated into monetary benefits for our insureds. We reduced our 1995 rates by an average of 7%, and announced in December that we would award a $2 million policyholder dividend in 1995 to eligible insureds. With this latest dividend, we have returned $9.3 million to our policyholders since 1989. None of our competitors can make this claim.

Cutting-Edge Loss Prevention Services

We are confident that through our comprehensive risk management practices and strong claims handling and legal defense stance, we have helped to create a positive claims environment in this state. Our hands-on, solutions-oriented risk management approach has gained a considerable reputation within the state. In evidence, PIC Wisconsin was awarded a contract in mid-year 1994 to administer the risk management services for the State of Wisconsin's Patient Compensation Fund.

Our highly-trained litigation specialists, together with the expert team of defense attorneys they work with, continually set new standards in protecting the reputations of our insureds. Since the company's inception, we have accrued a remarkable record, closing 86% of the claims against our insureds without indemnity payment and winning 81% of court cases in our policyholders' favor.

Enhancing Customer Service

Much of our focus in 1994 was directed to the new challenges in the marketplace, particularly expanding our capabilities to insure health care practitioners in any setting--from solos to multi-disciplinary groups to large allied provider networks. For 1995, we plan to continue this strategy while renewing our commitment to listening to our insureds, and providing them with the insurance solutions they need. Our three-prong service teams, consisting of litigation, underwriting and risk management specialists, exemplify our dedication to serving our customers' needs while respecting the unique qualities of each individual discipline.

One of our most ambitious accomplishments last year concerns our professional liability management system, known as CRUISE. Perhaps PIC Wisconsin's most massive undertaking, CRUISE is designed to streamline service to insureds, from invoicing, to tracking claims, to answering queries. While the immediate transition has not been without difficulty, we should see CRUISE emerge as the only software of this kind in the industry by year-end 1995. Even now, several companies have expressed interest in purchasing our CRUISE software, which can help defray the costs of its development.

Conclusion

As we reflect on the most successful year in the history of PIC Wisconsin, we know better than to become complacent with what we have achieved. We understand that by standing still, we are falling behind; that only by moving forward now will we succeed in the future. We will use the momentum gained from our successes in 1994 to propel us toward the challenges that await us in the coming year.❖

The word from WIPRO
Informing breast surgery patients about treatment options

Jay A. Gold, MD, JD, MPH

Last year, WIPRO conducted a project designed to improve the quality of information given to patients with breast cancer about the different forms of surgery available. What we learned provides lessons from which many patients, surgeons, and their staffs might profit.

The idea of the project came from a study conducted by Ann Nattinger et al at the Medical College of Wisconsin.[1] The study, based on 1986 data, found that among women with stage 1 or 2 breast cancer who were admitted for surgery, 7.0% had breast-conserving surgery (BCS). This was lower than the rate for any contiguous state, rather lower than the 12.1% national average, and far lower than the rates in some other regions of the country. This was noteworthy in view of the fact that 10-year survival rates for BCS accompanied by radiation therapy have been found to be at least as good as those for radical mastectomy, and that BCS has the advantage of removing less body tissue.

WIPRO formulated a study group made up of surgeons and other physicians (including Dr Nattinger), along with nurse representatives and a Medicare beneficiary. The group hypothesized that the relatively low BCS rate might be due to the way that information about the alternative procedures was given to cancer patients--that surgeons sometimes may harbor a preference toward mastectomy, and that this preference may be present in their communications about treatment options. This was supported by a study conducted by Drs. Polly Newcomb and Paul Carbone of UW (the latter of whom served on our study group), which found that only 31% of women aged 64 or less and 24% of those aged 65 or more recalled having the BCS option presented to them (as opposed to 90% and 89%, respectively, who remembered discussing mastectomy).[2]

While WIPRO (unlike the NIH Consensus Conference on the subject[3]) was not about to endorse BCS as superior to mastectomy where both are options, we do have a strong interest in patient empowerment. It is extremely difficult to measure directly the objectivity and completeness of communications between physicians and patients. If our study group's hypothesis was correct, however, it would follow that we could measure improvements in communication about

Continued on next page

Principles of Patient Education

- Start by identifying own bias or value system.
- Watch tone of voice and body language.
- Identify your perceptions that may be false.
- Assume patient sees herself as self-directed and independent.
- Ask for frequent feedback to assure patient comprehension.
- Be flexible.
- Allow time for decision making.
- Do not schedule surgery until the decision is made.
- Encourage patient to express fears and make every attempt to deal with them.

The word from WIPRO is not reviewed by the *WMJ* editorial board. Dr Gold is WIPRO's Principal Clinical Coordinator. He also serves as Assistant Clinical Professor of Preventive Medicine and Bioethics at the Medical College of Wisconsin, and as Senior Lecturer in Preventive Medicine at the University of Wisconsin, Madison. Reprint requests to Jay A. Gold, MD, JD, MPH, WIPRO, 2909 Landmark Place, Madison, WI 53713. Copyright 1995 by the State Medical Soceity of Wisconsin.

Continued from preceding page
breast surgery options by looking for increases in the rate of BCS performed, and that we could measure such communication improvements by looking for such rate increases.

We began our data analysis by looking at Medicare claims from March 1990 to September 1992 for breast surgery on women aged 65-79. While inpatient rates were only slightly higher than those Nattinger had found years earlier, the addition of outpatient claims--for a total of 4,115 procedures--showed that 21.8% of surgery for breast cancer in Wisconsin was BCS. (Rates in some other states are double that number.) The variation in rates of BCS ranged from 0-61%, unexplained by location, size, or type of hospital. The table shows the variation in rates of BCS as a percentage of initial surgeries for breast cancer in the 76 Wisconsin hospitals that submitted Medicare claims for such surgery.

Our next step was to choose hospitals to collaborate with us. We chose nine hospitals at random from among all hospitals whose BCS rates were 25% or less. We chose hospitals at varying distances from radiation therapy centers and ambulatory surgery centers. We also chose 10 hospitals we would not be visiting to serve as controls.

In planning our presentations, we spoke with surgeons at several hospitals whose BCS rates were either extremely low or extremely high, to discover what they were doing that led to those results. We also worked with Dr David Gustafson of UW on strategies for communication with patients.

Physicians from WIPRO, along with an RN project coordinator, visited the collaborating hospitals and met with staff that usually included surgeons, nurses, and administration. Discussions were uniformly lively, although reactions varied widely--from outright admissions of bias to outright denials. We spent much time discussing the principles of patient education. (See table.) In addition, we called attention to resources available for women with newly diagnosed breast cancer, including brochures and videotapes that could be used to give information about breast cancer treatment options. We suggested that such standardized resources could play a major role in the improvement process. Two hospitals chose not to undertake improvement plans; the rest sent improvement plans to WIPRO after the visits, and all but one of these stated that the hospital would be using a standardized packet of information.

WIPRO is about to begin examining the claims data for collaborating hospitals after our visits. If BCS rates in those hospitals have increased relative to state rates, it may be that participation in the project will have led to a greater empowerment of patients in this area. Even prior to follow-up analysis and regardless of its result, we believe that the principles of patient education have considerable merit, and we invite readers to apply them to their own practices.

Editor's note: The analyses upon which this article is based were performed under Contract Number 500-94-0606, entitled, "Peer Review Organization Contract for the State of Wisconsin," sponsored by the Health Care Financing Administration (HCFA), United States Department of Health and Human Services. The conclusions and opinions stated herein, as well as the methods employed, are those of the author. They do not necessarily reflect policies of HCFA. The author claims full responsibility for the completeness and accuracy of the data used in this article. This article was a direct result of the HCFA requirement that the Peer Review Organization of the HCFA requirement that the Peer Review Organization (PRO) complete and disseminate the results of projects, and required no special funding on the part of the PRO.

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2. Newcomb P, Carbone P. Cancer treatment and age: patient perspectives. *J. Natl Cancer Inst.* 1993:1580-1584.
3. NIH Consensus Conference: Treatment of early-stage breast cancer. *JAMA*. 1991:391-394.❖

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American Heart Association℠
Fighting Heart Disease and Stroke

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1995 House takes action on board reports, resolutions

Resolution 1 pertains to access to a state medical malpractice database and supports plan for SMS to urge the Office of Commissioner of Insurance to allow the release of closed claims without specific provider identification about all medical malpractice cases filed in that office to designated parties in the appropriate specialty society or to the regulatory bodies of the state. **Action:** substitute resolution adopted.

Resolution 2 calls for the SMS to oppose any legislation or policy that requires a physician to assist in, witness, or attend an execution. **Action:** substitute adopted.

Resolution 3 directs the SMS to encourage public health agencies to appoint a public health-trained physician as the public health officer. **Action:** substitute adopted.

Resolution 4 calls for the SMS to actively pursue legislation that requires firearms sold in the state to be sold with trigger locks. **Action:** substitute adopted.

Resolution 5 calls for the SMS to seek censure of the AMA president for political endorsement letters written on AMA letterhead. **Action:** not adopted.

Resolution 6 reaffirms SMS policy opposing legalization of physician-assisted suicide. **Action:** substitute adopted.

Resolution 7 directs the SMS to initiate legislation to require mandatory binding arbitration in medical malpractice cases before a panel consisting of an attorney, a physician, and a lay person chosen by both the plaintiff and the defendant, and further requires that a patient consent to participation in such a proceeding before the physician provides treatment. **Action:** another item was adopted in lieu of this resolution.

Resolution 8 calls for the SMS to study to determine reasonable capitation ranges for the various medical specialities. **Action:** referred to Board for study.

Resolution 9 asks the SMS to petition the AMA to work nationally to modify the CPT book to add a modifier to all services provided by middle level practitioners to reflect the different educational background provided in the service and allow the service to be statistically analyzed. **Action:** amended and adopted.

Resolution 10 asks that the SMS support statutory change granting physicians with $1 million/$3 million liability coverage by their primary insurer to be exempted from the Patients Compensation Fund. **Action:** referred to board.

Resolution 11 calls for the SMS to support a professional physician's component for every medical, surgical, radiological and pathology procedure listed in the current CPT manual. **Action:** adopted.

Resolution 12 recommends SMS support for an "any willing provider" law which prohibits exclusion or disenrollment of any duly licensed physician willing and able to provide care under acceptable professional standards. **Action:** board report B adopted as substitute.

Resolution 13 calls for the SMS to affirm its belief that the treatment of mental disease be reimbursed on an equal level with that of medical/surgical disease. **Action:** amended and adopted.

Resolution 14 calls for a convention of physicians, allied providers, consumers and payers to draft language for a Wisconsin Health Care Compact to delineate fundamental rights and responsibilities for each group. **Action:** referred to board.

Resolution 15 calls for the SMS to promote legislation that requires that each third party payor operating in the state provide its enrollees with a one-page summary of specific benefits, exclusions, any limitations on access to physicians and other services and enrollee financial obligations, written in a language understood by those with a 6th grade reading level. **Action:** amended and adopted.

Resolution 16 calls for the SMS to translate and publicly disseminate (on request) the data contained in the "HMO quarterly Summary Statement." **Action:** referred to board.

Resolution 17 asks for SMS endorsement of a legal provision stating that all insurance plans be required to offer a "point of service" option that would provide coverage for out-of-network services and that the actuarial data used by an HMO to justify an increase in premium or co-insurance requirements be required to be made public. **Action:** not adopted.

Resolution 18 endorses increased dissemination of information to physicians by all managed care organizations prior to contract signing. **Action:** amended and adopted.

Resolution 19 calls for the SMS to seek regulatory change to require health insurers in the state to reimbursement within 30 days of a bill's submission. **Action:** substitute adopted.

Resolution 20 calls for support of legislation requiring health insurers to offer financial incentives to physicians under managed care contracts that are based on fully disclosed, well defined quality of care guidelines, rather than the quantity of care provided, and that incentives to limit care be fully disclosed by plan administrators to patients on enrollment and later, on an at least annual basis. **Action:** not adopted.

Resolution 21 calls for the SMS to study the feasibility of replicating the Milwaukee Managed Care Check-Up Program on a statewide basis. **Action:** adopted.

Resolution 22 suggested the SMS work with appropriate public and private groups to achieve a consensus on the development and implementation of permanent uniform medical identification numbers. **Action:** not adopted.

Resolution 23 requested support of legislated change that would put small community hospitals and rural hospitals on an equal footing with urban hospitals. **Action:** not adopted.

Resolution 24 states that the Health Care Financing Administration and Medicare be notified that a greater number of primary care hospitals and clinics will not be able to accept Medicare patients due to inadequate reimbursement. **Action:** not adopted.

Resolution 25 calls for the SMS to take action against Medicare to ensure that reimbursement rates for rural hospitals for identical medical services be elevated to the same level as those provided by urban hospitals. **Action:** not adopted.

Resolution 26 calls for the SMS to reorganize as a professional physician guild. **Action:** not adopted as not permissible under the current Federal Labor Relations Act.

Resolution 27 requests that the SMS take action against Medicare to ensure that when down-coding is performed by Medicare, a prompt and immediate appeals method be available to the physician and patient. **Action:** not adopted.

Resolution 28 seeks an increase to 25 percent in reimbursement rates for assistant surgeons. **Action:** referred to the AMA Delegation with a report back to the 1996 State Medical Society of Wisconsin House of Delegates.

Resolution 29 seeks SMS action against Medicare to ensure that reimbursement rates for rural physicians be elevated to those in urban settings. **Action:** not adopted.

Resolution 30 seeks SMS action against Medicare to ensure that the appeals process for patients and physicians is prompt and takes place within 3 months. **Action:** not adopted.

Resolution 31 suggests that the SMS file an anti-trust complaint with the Department of Justice against a specific Wisconsin insurer. **Action:** not adopted.

Resolution 32 suggests the SMS take specific action against a specific Wisconsin insurer for its alleged efforts to "price fix." **Action:** not adopted.

Resolution 33 suggests the SMS file a complaint with the Justice Department with regards to antitrust concerns pertaining to a specific Wisconsin insurer. **Action:** not adopted.

Resolution 34 seeks SMS action on problems with physician exclusion from health plans in Wisconsin. **Action:** Board Report B adopted as substitute.

Resolution 35 seeks a convocation of health care providers, purchasers and payors to develop a pool to insure all residents of the state. **Action:** referred to Board of Directors.

Resolution 36 calls for the SMS to work to develop legislation to support the principals and medical staff bylaws are the legal rules of the medical staff and that all matters affecting medical staff members should be determined by the elected leaders, committees or due process, and that credentialing by a hospital of its employed physicians and decredentialling of on non-employed physicians shall be considered both anticompetitive and unethical. **Action:** substitute adopted.

Resolution 37 calls for the SMS to work with the AMA and Residency Review Commission to see all residents and trained and certified in basic life support and advanced car-

diac life support. **Action:** amended and adopted.

Resolution 38 suggests that the SMS work with the heart association to ensure that training in the use of automatic defibrillator is included in all ACLS, BLS and ATLS training for residents. **Action:** amended and adopted.

Resolution 39 calls for the SMS to strongly support a requirement that a rotation in emergency medicine be successfully completed before graduation from medical school. **Action:** not adopted.

Resolution 40 states that the SMS vigorously oppose any effort by limited license providers to gain independent prescriptive authority for all classes of prescriptive drugs. **Action:** not adopted.

Resolution 41 calls for the SMS to support physician directed and controlled transport of unstable patients between medical facilities. **Action:** referred to Board of Directors.

Resolution 42 directs the SMS to maintain a vigorous monitor of any efforts by allied health care professionals to seek legislation or administrative rule change that would allow a practice independent of physician supervision. **Action:** substitute adopted.

Resolution 43 calls for the SMS to work with pharmacists associations to better establish guidelines for the use of computer generated drug information. **Action:** referred to the Board of Directors.

Resolution 44 seeks legislation to codify state law to mandate that hospital medical staff bylaws be viewed as contracts. **Action:** substitute adopted.

Resolution 45 asks the SMS board to promote passage of legislation incorporating consent to share immunization records with the consent to the immunization itself. **Action:** not adopted in view of recent attorney general's ruling.

New SMS President Marcia J.S. Richards, of Milwaukee, takes the oath of office. Dr Richards is the second woman to hold the SMS presidency, following Pauline Jackson, MD, who served two years prior.

Resolution 46 calls for rural emergency transport services to be upgraded as is provided for urban areas. **Action:** referred to Board of Directors.

Resolution 47 urges the SMS to take action with the insurance commissioner to require that professional review organizations as hired by various insurance companies be registered and licensed by the state; an appeals process should be established and when errors are discovered, the organization s ability to review in Wisconsin should be retracted with monetary penalties. **Action:** not adopted.

Resolution 48 calls for the SMS to poll its members of the value of WIPRO. **Action:** not adopted.

Resolution 49 seeks to eliminate cost barriers for the vaccine for children program by working with the AMA to expand the program so children who have health insurance that does not cover vaccinations could receive vaccinations. **Action:** not adopted.

Resolution 50 urges the SMS to work to limit the availability of ephedrine. **Action:** adopted as amended:

Resolution 51 calls for the SMS to pay expenses for resident, student and alternate delegates attending the state annual meeting. **Action:** amended and adopted.

Resolution 52 seeks funding and support for the CESF Medical Outcomes Research Project. **Action:** amended and referred to Board of Directors.

Resolution 53 establishes an SMS section for cardiothoracic surgery. **Action:** adopted.

House of Delegates Nominating Committee: 1995-1996

District 1
Lucille B. Glicklich, MD, 2000 W Kilbourn Ave, Milwaukee 53233
William J. Listwan, MD, 205 Valley Ave, West Bend 53095
Timothy G. McAvoy, MD, 1751 E Main, Waukesha 53186
Thomas A. Reminga, MD, 330 E Kilbourn Ave, Ste 730, Milwaukee 53202
John E. Ridley, III, MD, 2315 N Lake Dr, Ste 1001, Milwaukee 53211
Gregory A. Shove, MD, 2405 Northwestern Ave, Racine 53404
Frank H. Urban, MD, 3645 Emberwood Dr, Brookfield 53005

District 2
Adam H. Balin, MD, 753 N Main St, Oregon 53575
Jerry M. Ingalls, MD, 515 22nd Ave, Monroe 53566
Paul A. Wertsch, MD, 4221 Venetian Ln, Madison 53704

District 3
Mark H. Andrew, MD, 125 W Jefferson, Viroqua 54665

District 4
Ali K. Choucair, MD, 1000 N Oak Ave, Marshfield 54449
Robert J. Jaeger, MD, 3291 Thompson Ct, Stevens Point 54481

District 5
David R. Weber, MD, 80 Sheboygan St, Fond du Lac 54935

District 6
Joseph C. DiRaimondo, MD, 1636 Miriam Rd, Manitowoc 54220

District 7
Philip J. Happe, MD, PO Box 1510, Eau Claire 54702-1510, chair

District 8
Joseph M. Jauquet, MD, 1625 Maple Ln, Ashland 54806, secretary

Specialty sections
Richard S. Kane, MD, 945 N 12th St, PO Box 17932, Milwaukee 53217❖

Resolution 54 calls for the SMS to research modes of electronic communications and develop an educational program for physicians. **Action:** adopted.

Resolution 55 calls for the sale of the SMS headquarters to be brought before the House of Delegates. **Action:** Report D, section on sale of SMS property, adopted in lieu of Resolution 55.

Resolution 56 urges the AMA to aggressively support physician members and their practices in whatever capacity when conflicts arise between insurance companies, managed-care organizations and provider groups to insure that high-quality health care will be provided to patients. **Action:** amended and adopted.

Resolution 57 urges the SMS to not participate in any manner in the current federal antitrust case involving Marshfield Clinic. **Action:** Board report G adopted in lieu of this resolution.

Resolution 58 seeks that the counts involved in the Marshfield federal antitrust conviction be published in the *Wisconsin Medical Journal*. **Action:** not adopted.

Late Resolution 59 limits use of the MD title. **Action:** adopted.

Late Resolution 60 directs the SMS to urge state to create a separate and distinct Department of Health which will emphasize public and environmental health programs and services; support such legislation working in concert with other health organizations and call for the department of health to be headed up by a graduate of an accredited school of public health or medical school graduate program in community health and preventive medicine preferably with a doctorate in public health, or a Ph. D. or an M.D. with a masters in public health and public sector. **Action:** substitute adopted.

Late Resolution 61 pertains to the Wisconsin statute for HIV testing. **Action:** Report F adopted as substitute and resolution referred to Board of Directors.

Late Resolution 62 calls for the SMS to pursue legislation to prohibit managed care entities from inserting language in their contracts with physicians that hold the managed care organization harmless if harm befalls a patient as a result of the acts or omissions of the managed care organization. **Action:** substitute adopted.

Late Resolution 63 calls for SMS support of medical liability reforms. **Action:** adopted Report A, section on medical liability reform, as substitute

Late Resolution 64 seeks that the SMS reaffirm its belief that same reimbursements be given for same Medical Assistance service. **Action:** adopted.

Late Resolution 65 reaffirms SMS support of the universality of the medical profession and its celebration of the profession's cultural diversity. **Action:** adopted.

Late Resolution 66 pertains to HIV testing of pregnant women. **Action:** Report F adopted as substitute and resolution referred to Board of Directors.

Report A includes sections on mandatory binding arbitration; medical liability and prohibiting recovery from unnamed parties; Patients Compensation Fund/rate relativity review; 1994 House of Delegates Resolution 1-Protection of Children from Handguns Act; tobacco regulation; and a policy statement on prenatal care documents. **Action:** adopted.

Report B includes sections on: 1994 House of Delegates Resolution 29--resolution to include phase one through three research protocols not covered by benefits in the basic benefit program for state employees administered by the state employees trust fund; 1994 House of Delegates Resolution 50--fee-for-service plans in health care reform; House of Delegates Resolution 53 medical IRAs (Medisaver accounts) and 1994 House of Delegates resolution 56 Medical savings accounts; prior authorization; *WISCONSIN CARE* refinements and the Medicaid primary provider program. **Action:** adopted.

Report C includes sections on denying prescribing authority to psychologists; procedures regarding ethics on medical information confidentiality; and appropriate case management of AIDS. **Action:** adopted.

Reference committees: 1995

State and National Issues
James Siepmann, MD, Oshkosh, Chair
John Petersen, MD, Wauwatosa
Vijay Kulkarni, MD, Milwaukee
Pamela Wilson, MD, Madison
David Hoffmann, MD, Mauston

Socioeconomic Activities
Charles Link, MD, La Crosse, Chair
Daniel Gilman, DO, Milwaukee
Reynaldo Gabriel, MD, Cudahy
Robert Shapiro, MD, Madison
Homer Russ, MD, Marshfield
Mark Belknap, MD, Ashland

Scientific Activities
Dean Stueland, MD, Marshfield, Chair
Kathleen Wick, MD, Beloit
Gregory Shove, MD, Racine
John McDermott, MD, Madison
Ali Choucair, MD, Marshfield
Wendelin Schaefer, MD, Sheboygan

Organization and Finances
James Concannon, MD, Kenosha, Chair
William Greaves, MD, Milwaukee
Armond Start, MD, Madison
Paul Leehey, III, MD, La Crosse
Kevin Quinn, MD, Neenah
Stephanie Wojtowicz, Madison
David Drake, Milwaukee

Credentials
Ed Mathews, MD, Milwaukee, Chair
Donald Beaver, DO, Elm Grove
Robert Cooney, MD, Portage❖

Report D includes sections on 1996 dues recommendation, officer compensation, policy on harassment, the budget and the strategic plan. **Action:** portion on budget filed; all other sections adopted.

Report E pertains to the surrogate decision act. **Action:** amended and adopted.

Proposed Constitutional amendment increasing the number of medical student delegates from one to four; two from each medical school. **Action:** adopted.❖

Presidential address
Such a state

SUCH A STATE I'm in .
I'm in a state of **admiration,** because

I'm in a state whose national ranking is near the top for health status and near the bottom for health care costs.

I'm in a state which has the highest level of insurance coverage of any state— 92.4%, we recently passed Hawaii.

I'm in a state where acting responsibly is taken seriously by patients, physicians, and yes, even politicians.

The health system in Wisconsin works, and it works well. In general, our citizens enjoy reasonable access to high quality care at an affordable price. Each one of us in this room can take a little credit for and a lot of pride in Wisconsin's medical success.

But that success has not come easy and it will not continue without our hard work.

I visited with a solo doctor in Kiel who fears that he can't keep up the pace, especially as the only physician in his area who accepts new medical assistance patients. Dr. Deubler, you have my admiration.

I spoke with a successful medical group in Milwaukee that could have rested on its laurels, but chose instead to develop new relationships, to meet head on the challenges of an ever-changing practice environment. Milwaukee Medical Center, you have my admiration.

I gave an award to a physician in Osceola who had skillfully and compassionately served his community for many years. The fact that most of the town showed up for the ceremony was evidence that he has not only followed, but he has also created, a noble tradition of professional and civic service. Dr. Simenstad, you have my admiration.

Dr Roberts hammers in a point during debate in the SMS House of Delegates.

I attended a county medical society meeting in Janesville that included bankers, clergy, insurance executives, law enforcement officials and even some doctors. In the midst of a hospital war, the county society president managed to bring the physicians and community together through a model CHILD SAFE project. Dr. Murdy, you have my admiration.

I have dozens, indeed thousands, of other examples of Wisconsin physicians who make a difference each and every day and who have my admiration.

Such a state I'm in.
I'm in a state of **exultation,** because I'm in a state where an initiative like CHILD SAFE can happen.

I'm in a state where CHILD SAFE can generate numbers like 3 million,

200 thousand, 20 thousand, and 10 thousand. An estimated 3 million people heard the CHILD SAFE message, $200 thousand was pledged by Blue Cross Blue Shield United of Wisconsin Foundation, 20 thousand information brochures were distributed, and 10 thousand trigger locks were given away. More than half of our county societies have projects underway, hundreds of doctors have stepped forward to lead in their communities.

And so I'm in a state of exultation over the success of CHILD SAFE.

But every silver lining has a cloud.

Such a state I'm in .

I'm in a state of **trepidation,** because

I'm in a state where the unseen hand of the medical market appears to be wrapping its fingers around the throats of our patients, to be shaking a fist in the face of our profession.

I'm in a state where medical entrepreneurs, specialty frictions, and capital intense financially driven monoliths fray the edges until they threaten the very fabric of the successful tapestry of caring that Wisconsin medicine has woven.

In his book Divided We Fall, historian Haynes Johnson wrote of his concern that the American motto "E pluribus unum" ("out of many, one"), had become "out of one, many." Well it's felt a little like the Wild West out there at times. As we are tempted by the territorial frenzy to carve medical turf, we must remind ourselves that there was a frontier ethic among the pioneers who joined in the land rush. It was a policy of enlightened self interest: of celebrating the individual while cooperating for the community, of enjoying the fruits of one's labors while voluntarily sharing one's bounty.

John Kennedy advised that "we should not let our fears hold us back from pursuing our hopes." It's easy to be afraid right now. The pace of change accelerates; the uncertainty aggravates, the self-centeredness predominates: primary versus specialty care, systems against solo, reimbursed over uncompensated. If we give in to these venalities, then we have held ourselves back from pursuing our hopes. Our hopes of an even better Wisconsin where all its citizens have ready access to the best quality and most appropriate care at an affordable price. If we allow this hopeful vision to blur, then we risk that which we physicians fear most: irrelevance.

Such a state I'm in .

I'm in a state of **expectation,** because

I expected that Wisconsin's doctors might be mildly interested in a program of community leadership, but I did not know that CHILD SAFE would be the overwhelming success that it has been. Thank you all for answering the call.

We had a President's Team this year which was nominally created to focus staff efforts for CHILD SAFE. Over the course of the year however, the President's Team included virtually every member of the staff at one time or another. The staff did more than work on CHILD SAFE, they made it possible. Even better for me was that they made it fun, even joyful at times.

I expected that the SMS staff would be good, and they were. I expected that the staff would work hard, and they did. But I did not know how much they care. We are blessed with people who work very long hours, travel many miles, eat countless vulcanized chicken dinners, and subject themselves to our unpredictable egos. I wondered, why would anyone want to do such a thing? I found out. It's because they care, deeply. It's because they believe in the vision and in the hope, even when we physicians sometimes lose sight of that vision and despair about the hope. So please make it a point during this meeting to stop at least one of the staff to say thank you. Thank you for your caring, for your good work. Join me now in thanking them together.

Such a state I'm in.

I'm in a state of **appreciation,** because I was **privileged**

- privileged to have a wonderful family that hung in there with me despite too many nights away;
- privileged to have travelled to the White House on health reform and yes, to the dog house on nurse prescribing;
- privileged to follow giants, one of whom, JD Kabler, reminded us that medicine should be serious, but not grim;
- privileged to have a turn as your ambassador to thirty six Wisconsin communities and a half dozen other states and to be thankful to have medical society flights take off 54 times and land safely 54 times.

But mostly, I'm in a state of eternal appreciation because you allowed me to briefly touch your lives, to speak to your hopes, and to serve as an inadequate representative of all that you do and all that you are. And that is really quite something. It's been a life changing experience to serve as President of this very special Medical Society in this wonderful state of Wisconsin. Such a state we are in. I'll forever cherish the memories and I thank you for the honor. Be good to each other.❖

Address of the president elect
Advocacy in a managed care environment

I AM HUMBLED TO BE here tonight as the one hundred and forty-second president of the State Medical Society of Wisconsin. I am also proud to be the second woman president of this organization. I thank you for giving me the opportunity to serve you.

Let me take a moment to commend Rich Roberts, who has been an exceptional president with endless ideas and endless energy, but fortunately for me, and probably for him as well, not an endless presidency.

Rich--We all expect to hear more from you in areas of medical and social leadership-and yes, we will campaign and vote for you when you run for public office.

Thanks to those of you who have been my mentors. You provided me with help and support and lives to emulate—even when you did not agree with me. I especially appreciate the members of my group, Radiation Oncology Associates, who have agreed to support and cover for me during my year as your president. You may not know what you are in for. But thanks very much, all the same.

To Pauline Jackson, the first woman to lead our state society, and Lucy Glicklich, who preceded me as the first woman president of the Medical Society of Milwaukee County, I give special thanks for being my role models. They both cracked open the glass ceiling of medical society leadership and I followed each as the second woman. I hope others will follow me.

As president, I will reach out my hand to the women physicians of Wisconsin and support them in their efforts to actively participate in this organization, so that the State Medical Society may truly represent all Wisconsin physicians. My presidency comes with challenges for all of you: Help break down the barriers. Let's examine our society's organizational structure to make it easier for all our younger physicians, both male and female, to actively involve themselves in our organization. Let's explore new communication technologies to provide doctors with more accessible ways to involve themselves in policy-making and planning. Our current conventional organizational structure is often incompatible with the demanding lives beyond medicine, for many younger physicians, regardless of gender.

Marcia J. S. Richards, MD

As I stand here tonight, I am thankful to so many people. But most of all, I want to thank my husband Don--and by the way I am also the second woman in his life--and my daughter, Maura. They have both encouraged me to be active and involved in the organizations and causes I value. Thanks for tolerating my time away while I pursued these activities and for warm welcomes when I return home.

Two hundred years ago Thomas Jefferson said, "There are extraordinary capabilities in ordinary people, given the opportunity." ...Well, I believe we have reached that door of opportunity and in 1995 and 1996 I intend to give the medical society my very best. I won't be the second woman any more!

When faced with an opportunity, and I choose to believe that the current environment of medical practice is an opportunity, the problem with most of us is not that we aim too high and we miss our goal, but that our aim is

too low and we reach it.

Now why would I say that, you might ask? Because, surely, as physicians we are doing everything within our power to provide excellent care to our patients. How can we do anything more than that?

We can do more--we must do more--because our patients need us to do more. Let me explain.

Here in my hand is the book containing health care insurance options for employees of the State of Wisconsin. We receive this book because my husband is a retired UW professor.

Look at this book; it's almost an inch thick with more plans to choose from than VCRs at Best Buy. But what does it tell me? It's easier for a Wisconsinite to make an informed choice when buying a household appliance, than it is to determine how to purchase health insurance. Let me give you an example.

Recently I was in the market for a VCR. I listened to the salesperson extol the virtues and shortcomings of each make and model. Then I read the information provided by the manufacturer. I also studied Consumer Reports and Stereo Review publications to find out what I should consider when purchasing a VCR. These magazines discussed the various options and features of VCRs--some of which I cared about and some that I didn't--and included ratings of various brands and models. I then purchased my VCR, but only after choosing to make an informed decision. (After all, if I am unable to easily record the Figure Skating Championships or Wall Street Week when away at medical society meetings, I will be a very unhappy lady).

When I bought my VCR, I was comfortable that I had made a well-researched choice. Yet I could not easily find any information to assist me in making a choice between these multiple health insurance plans. Fortunately, being a physician, I had insider information.

Most of our patients, however, lack the needed resources to make good decisions about their health care. Consequently, too often the decision is made only on cost. Yet, few Americans choose to purchase the cheapest VCR--they would be afraid they would sacrifice quality and end up paying more for repairs. So they shop around carefully and purchase the VCR with the options they desire.

But when it comes to health insurance--something that has the potential to be a life or death matter--no one provides easily available and uniform information to our patients to assist them with decision-making. Here is an opportunity for patient advocacy that I believe we cannot afford to miss.

So much is at stake as we move ahead. In the midst of this historic transformation of our health care delivery system, patients and physicians feel the earth moving under foot. It's unsettling, and we are not even in California! But to regain our equilibrium, we can reach out our arms to steady each other. Side-by-side, we will find the steady support we need to go forward and flourish.

I will focus my presidential year on advocacy for patients and their physicians in this new practice environment increasingly dominated by managed care. Let me first make it clear that I do not believe that managed care is a common enemy, rather it is only a new and different system for delivery of medical care. Managed care is not yet mature enough for me to make a judgment call on its merits. As a developing system, I believe it is still also young enough for us, as physicians, to influence its evolution if we take the opportunity.

I also believe that the rise of managed care through market reform, rather than through regulatory or major legislative reform, offers us as physicians a window of opportunity to be advocates for our patients, and offers the medical society a better opportunity to be the collective advocate for physicians in areas of common concern. It is up to us, as the most knowledgeable individuals about health care, to grasp this opportunity for the future.

Mark Twain once observed, "There is no distinctly native American criminal class except Congress."

That remark echoes with humor as Samuel Clemens intended. But I think far too often the cynicism it nurtures causes us to abandon our posts as advocates, for ourselves and our patients, and throw up our hands in despair. We've forgotten that Congress is "government by the people, for the people." And if we want Congress to make changes in health care delivery that ensure quality care for our patients, "We the People" and we the physicians, have to get involved.

We must also advocate for each other and our profession. As was said by Rabbi Hillel, "If I am not for myself, whom am I for?" As Doctors, we too can feel overwhelmed, just like our patients do when presented with these (show stack of managed care contracts from ROA). A total of four boxes like this would contain the files for the managed care contracts in which my small single specialty group participates. As physicians--if I can judge from the conversations in the medical staff lounges and from my own experience--we are often ill prepared in dealing with managed care entities. We can then empathize with our patients who are likewise ill-prepared to evaluate the insurance products offered by these same companies.

This is also a time when increasing issues divide us as physicians into different factions.

Medicine, like the American society, is becoming increasingly diverse. With diversity we find many differences in values, perceptions and priorities. Just think of the difference in physician views between young and old, rural and urban, generalist and specialist, group and solo practice, and town and gown. We must as physicians be willing to get involved in a constructive manner, providing unified and cohesive feedback and input. I believe if we do not take this opportunity, others who are not physicians are standing in line to mold the future of the practice of medicine.

I am here tonight to challenge you--the physicians of Wisconsin, and our State Medical Society--to seize this opportunity and unite. Don't give others the opportunity to storm a house divided.

Advocacy for issues on which we all agree will be easy to pursue. For example, we can all stand together on the issue of patient advocacy.

But I do not think that we as a society should always pursue issues of only the lowest common denominator. Rather, we should support efforts for various groups with common interests where ever there is critical mass of members within our organization. If smaller numbers of physicians have a common concern, perhaps the society should function as a catalyst to bring these individuals together. Our diversity brings challenges, but it is the mainstay of the House of Medicine. We can celebrate our diversity just as our forbearers celebrated America as the melting pot.

Let me share with you six potential areas I see for patient and physician advocacy in our new managed care environment.

First, we need to ensure that medical decisions for our patients are made by physicians.

Second, we must ensure that the policies and procedures for physician credentialing and evaluation are medically and ethically reasonable.

As a third point of advocacy--and one I referred to earlier in my discussion of health care plans and VCRs--we need a standard methodology for providing feedback on the quality of patient care, and for monitoring patient and physician satisfaction within different health plans.

In a similar fourth area, we need to provide education for both physicians and their patients on how to evaluate options presented to them by the same health plans.

Fifth, we need to educate both physicians and their patients on new conflicts of interest that may arise in a managed care environment.

Lastly, I strongly believe we need to participate actively in the shaping and molding of the managed health care delivery system, recognizing that it is an evolving system. If we don't, I can guarantee that others will.

These six examples are not meant to be a comprehensive listing of all areas for patient and physician advocacy in a managed care environment. I hope you will help me to explore ways we can make a difference in these areas and identify others where physicians, either singly, or collectively through our medical society, can become involved.

Increased emphasis on patient and physician advocacy by the State Medical Society of Wisconsin is not just my idea, rather it is the number one priority of you, the 8,000 members of the State Medical Society. That's what you expressed in the recent membership questionnaire. I think it is appropriate that I, as your president, carry your charge as my theme.

Together this next year, let each of us personally, as well as the commissions, committees and board of our society, reaffirm our commitment to look for areas in which to function as an advocate in the name of our profession. We, the physicians of Wisconsin, must reemphasize publicly our role as the premier advocate for our patients, and our medical society as the premier advocate for physicians in the new milieu of managed medical practice. Let us together discover organizations with which we may become allied, find new issues to support, identify individuals and groups to defend, and above all promote rededication to the principles of medical practice to which we all subscribe.

Throughout the year, I hope we can work collaboratively on honing our advocacy skills for patients, and, as a medical society work on developing the necessary skills to thrive in this new environment of managed care. If we, and our society, do this successfully, and I believe we can, then the practice of medicine tomorrow will not just be different, but will be brighter and better for tomorrow's physicians and their patients. Let us pursue together this vision. Let's keep Wisconsin medicine number one.

I just won't settle for number two!❖

EVP report to the House of Delegates
On the wings of tort reform victory

I AM PLEASED TO announce that on Thursday, April 6, 1995, genuine tort reform completed its tortured 8-year path through the Wisconsin Legislature. The Senate and Assembly have agreed on a bill that is now on its way to the governor's desk.

This victory should serve for us as a symbol of what we can do when we work together, because it would never have been achieved without the combined efforts of a large number of physician volunteers and dedicated--sometimes impassioned--staff members. I note, in particular, past SMS president Dr. Bill Treacy and former lead SMS lobbyist Terry Hottenroth, as well as our current Capitol team: Mike Kirby, Kathy Andersen and Colleen Wilson.

While these have been the stars of our campaign, the credit for this victory must be shared with the entire SMS staff and a host of physician leaders, key contacts, commission members and chairs and grassroots activists. It has always been the collegial atmosphere and respectful working relationship among staff and physicians that has set this medical society apart, so it is fitting that it was our ability to pull together that has gained us this milestone.

And it is in the spirit of that relationship that I offer these observations: I am your executive vice president; I do not belong to any county medical society, specialty society, or practice group. When I view the medical profession, my job is to see it in its entirety: from the family physicians to the sub-specialists; from the solo practices to the super groups; from the urban milieu of metropolitan Milwaukee to the rural framework of Forest County. And when I scan the field, I see danger stirring.

Thomas L Adams, CAE

The unsettling part of this danger is that it is not the creation of some exterior foe. The greatest threat to the profession now comes from within your own ranks. There are too many dividing lines among physicians now, too many opportunities for physician unity to fail. "A house divided against itself cannot stand," the scriptures remind us, and so it is with the House of Medicine. Your own divisibility is now your greatest enemy.

The danger, of course, is understandable. The practice of medicine is undergoing recurrent spasms of change, and physicians must both adjust to these changes and prepare to adapt to those that are coming. Many of the comforts enjoyed by physicians in the past are being lost, but perhaps the greatest injury is the loss of certainty. The professional life of a physician has gone from being one of the most secure to one of the least in less than a decade. The insecurities and threats wrought by these cataclysmic changes can make us perceive adversaries in every shadow, mistrust our friends and turn healthy competition into something perverse and destructive.

The time has come to stop, take a deep breath, and remember that physicians are physicians first--and that all other considerations are secondary.

We must be careful not to let competitive zeal override our common sense and common goals. When I was working in a U.S. Senate office several years ago, the senator got an urgent call from another staff member. "Your chief of staff has just died," the ambitious young man said, "and I'd like to know if I can take his place." The senator thought it over for a moment and said, "It's OK with me if it's OK with the undertaker."

Or, as comedian Lily Tomlin likes to say, "The trouble with the rat race is, even if you win, you're still a rat."

Economic insecurities and changes in the managed care environment are not the only potential causes of division among your ranks. The membership of the State Medical Society of Wisconsin is, by all accounts, a diverse group. You represent some 97 specialties and subspecialties. Roughly ten percent of you are in solo practice, while the other 90 percent are in groups that range in size from 2 to more than 400. Our surveys of your opinions on issues show that, as a group, you can be categorized as neither conservative nor liberal, but as a broad range of passionate values and beliefs. The numbers of physicians who are women, minorities and trained abroad are growing rapidly, and this, too, adds to the rich spice of the mix.

When we ask SMS members why they have joined, there are literally dozens of answers. That says something about both the physicians and their state medical society. First, it is another strong signal that the medical profession is made up of a lot of very different people with widely divergent interests. Second, it is a good sign that the SMS reflects that diversity and is an organization that provides outlets for expressing those many interests.

The SMS provides the opportunity for physicians to come together, work together, achieve together, as physicians--regardless of whatever else may divide them. Is this easy? It is not. But as Dr Martin Luther King Jr. instructed us: The ultimate measure of our character is not where we stand in moments of comfort and convenience, but where we stand at times of challenge and controversy. Confronting an especially difficult challenge forces us to use all the tools at our disposal, to bring emotion as well as intellect to bear. The paradoxical result is that sometimes the higher the goal, the higher our chance for success.

The most immediate goal for the members of the SMS must be to recommit themselves to a unified House of Medicine.

We can talk about how the SMS is designed to be responsive to its member physicians, and of how well it actually does respond, but the quick and clean way of saying it is this: The SMS is yours. It is physician-created and physician-directed. Its priorities, policies and procedures are all determined by its physician members.

Those determinations have been brought together in a strategic plan, which your Board of Directors has submitted for your consideration during the deliberations of this House. The consideration of such a plan also gives us the opportunity to enact the late Dr. J D Kabler's formula for a public address: Point to the past with pride; view the present with alarm; look to the future with confidence.

This medical society, more than most others, can honestly point to the past with pride. For more than 150 years, it has pursued public policy and medical practice goals designed to advance the health and well being of Wisconsin's citizens. This medical society has contributed more than any other institution or any other group of people to the length and quality of life enjoyed by the people of this state.

We may view the present with alarm because of the threat of factionalism within the society's membership. This society cannot be all things to all physicians, and I can guarantee that at some point in the next year, you will disagree with something the SMS says or does. That's OK. That's how it should be.

One of the most frequently criticized federal agencies is the Federal Communications Commission, but when Newton Minnow headed the agency, he complained that his biggest problems came from his mother. She called him up and said, "Newton, since you've been in that job, the TV programs really have gotten much better--but can you do anything about the TV dinners?" Regardless of how efficient and successful your SMS is, some members are going to be disappointed--chiefly because the goals and priorities of the SMS cannot be the exact goals and priorities of each of its members. This is a democratic organization, and democracy is progress through the compromises made by competing interests.

The ability of SMS members to work together despite your competing interests will be tested by a number of contentious issues likely to arise in the coming months, and by resolutions you consider here in the next three days. Issues raised by a bill supporting physician-assisted suicide, by the Marshfield legal battle and by the Medicare payment area survey, among others, will probe this organization's core and explore its strengths and weaknesses.

When Conrad Hilton was retiring from the hotel business, he was asked what advice he could give his successor. "Remember," Conrad said, "to put the curtain inside the tub." The message is to mind the basics, to take care of your own house, first. Physicians must secure the House of Medicine first.

I believe that we can look to the future with confidence precisely because of our past accomplishments and the caliber of people who make up this organization. Being careful first to put the curtain inside the tub, we turn our attention to home improvement projects.

What we have built is grand, but goals are only good if they are continually revised upward. My grandfather used to tell me that old age was always 15 years older than he was. In the same way, success should always be seen as something greater than what we've already attained.

On the other hand, we must stay aware of our swiftly changing environment and prepare to adapt accordingly. Yes, sometimes circumstances beyond our control force a change in our lives. And sometimes that brings out the best in us. Asked

once how he got to be a war hero, John Kennedy replied: "They sank my boat."

Evaluation and adjustment must be built into any strategic plan. And the measurements must be made in time to change course before too much effort and money has been expended. Otherwise, every initiative ends up illustrating the old Pentagon axiom: There are two phases to any program--too soon to tell and too late to kill.

Having a platform from which the physician voice can be articulated and amplified is essential in today's highly volatile, politically charged medical environment. The world in which your profession works, and perhaps your profession itself, is currently the object of a host of ardent reformers, some powerful, some misguided and some treacherous. Like it or not, the Medical Society will speak for physicians in this debate. And speaking in a collective voice--with the strength of numbers, organization and professional staff behind you--will give you far greater opportunity to shape the coming reforms in ways that are healthy for both your profession and your patients.

That collective voice is found in the State Medical Society of Wisconsin. Let me rephrase that: The physician voice is heard through the SMS regardless of whether you or your colleagues join. Members or not, physicians are represented in the SMS by county society delegations and the delegations of your specialty societies. Members or not, when the SMS speaks the state hears it as your voice. It would seem only prudent, then, to join forces through the SMS and work to make certain that this voice of medicine is saying the things it ought to be saying.

My hope is that the physicians of Wisconsin will respect each other's differences, draw on each other's knowledge, heal each other's wounds, and promote each other's progress. In working together, you can help each other. In working together, you can help your patients. Alone, a physician can touch a community; together, you can change a state--even a nation.

I've said my piece; now comes the hard part. It's time for you to think. Think about your dreams as physicians. Think about your goals as citizens of local, state and national communities. Think about the future of your profession and your patients. And then consider the importance--to all of these--of your involvement in organized medicine and of your commitment to a united House of Medicine.

Let me close with the words of Longfellow:

Let us, then, be up and doing,
With a heart for any fate;
Still achieving, still pursuing,
Learn to labor and to wait.

Thank you.❖

These days *profit* doesn't just *WALK IN THE DOOR.*

America has 49 million money-spending people with disabilities. That's a lot of customers for restaurants, stores, theaters and other retail businesses that make their premises accessible to disabled people.

GIVE ABILITY A CHANCE

No kidding!

The 1995 Annual Meeting included activities for children and families.

Awards given by SMS in 1995

EACH YEAR, during its annual meeting, the SMS recognizes leaders in health care, both physicians and non-physicians, who have made significant contributions to the health and well-being of Wisconsin residents. The following awards were presented during the 1995 annual meeting in Lake Geneva.

John K. "Kim" Scott, MD, of Madison, (l) receives the SMS Directors Award, the highest honor bestowed by the SMS, from then-SMS Board Chair Richard H. Ulmer, MD.

Director's Award

The Director's Award is the highest honor bestowed by the SMS and is only granted on occasion to those who have served with outstanding distinction the science of medicine, physicians and the residents of the state of Wisconsin.

John K. Scott, is the 1995 recipient of the SMS Director's Award. A former president of the state medical society, Dr Scott is also a past president of the Dane County Medical Society, American Cancer Society Wisconsin Division, and the Wisconsin Chapter of the American College of Surgeons. He is a member of the American Academy of Ophthalmology and Otolaryngology, Society of Head and Neck Surgeons, and the American Laryngological, Rhinological and Otological Society.

Dr Scott earned his medical degree from the Ohio State University College of Medicine. He is board certified in otolaryngology and practices in Madison where he is affiliated with Physicians Plus. Dr Scott is a clinical professor of surgery (ENT) at the University of Wisconsin Medical School, Madison, and is a fellow in the American College of Surgeons.

Dr Scott has represented Wisconsin physicians at the American Medical Association since 1976 and served on the AMA Council for Long Range Planning and Development. He chaired the Wisconsin American College of Surgeons Commission on Cancer, served on the SMS Cancer Committee and has been a national delegate to the American Cancer Society since 1972. In recent years, he has become a major player in the international arena, serving as the sole U.S. delegate to the International Society of Doctors for the Environment.

Dr Scott is the secretary-treasurer of WISPAC--the political arm of the SMS--a post he has held since 1980. He has actively participated in the development of medical-related legislation in our state, going one-on-one with state lawmakers to make sure the concerns of Wisconsin physicians continue to be heard.

Presidential Citation

Each year the president of the State Medical Society, with the approval of the SMS Board of Directors, has the privilege of honoring an outstanding individual or individuals with the Presidential Citation. Richard G. Roberts, MD, JD, focused much of his presidential term around the development of the Children's Health Initiative with Local Doctors for Safety and Firearm Education--more widely known as CHILD SAFE. Many, many groups and individuals across the state have been involved in the move to encourage youth to live without violence.

"In this politically correct world, youth have become the chronologically challenged," Dr Roberts noted. "Their ideas are too often dismissed by adults and faced with this constant demeaning rejection, many youth give up their dreams to make the world a better place. My heroes didn't give up; they planned ways to implement their ideals, they hurtled adult-imposed barriers and they excelled."

With the approval of the SMS Board, Dr Roberts presented the

Richard G. Roberts, MD, JD, offers his congratulations to Timothy J. Van Susteren, PhD, of the Medical College of Wisconsin, on his selection as recipient of the 1995 Distinguished Service Award. Dr Van Susteren currently serves as the director for continuing education for the Medical College where he administers and directs more than 300 educational programs annually for physicians, nurses, psychologists, social workers, administrators and other health care professionals.

Presidential Citation to several groups who have demonstrated superior commitment to the health and safety of Wisconsin youth while expressing the hope that this tangible expression of richly deserved recognition will be displayed where it can encourage current and future leaders to carry on.

Presidential Awards of Honor went to those individuals who have made a real difference in the outlook for their communities through their leadership in these and other groups. Among those honored were:

1) Wausau Boy Scout Troop 465.

Scouts from Wausau Boy Scout Troop 465 spent a Saturday in January distributing 150 trigger locks at the Wausau Center Mall. The troop also held a CHILD SAFE poster contest at the mall. Two weeks following the distribution of the locks, the troop followed up with the people who received free trigger locks to see if they had actually placed the locks on their guns. The troop's advisor for this project was Dr Jeffrey Lamont, a Wausau pediatrician. Dr Kevin Flaherty, of Wausau, accepted the award on behalf of Troop 465.

2) James Madison Memorial High School--Student Peer Mediation Council.

The Madison student peer mediation council works toward educating youth on the importance of nonviolent resolution. The peer mediation council started in the spring of 1994 and this group of students demonstrates a strong commitment to peer mediation through both their regular participation on the council and their educational outreach to students, staff and the community. Margaret Micke is the council's advisor. Dr Robert recognized the following individuals for leadership efforts and gave certificates of honor to the following students who helped start and develop this important initiative: Sachin Chopra-Grade 11; Jocelyn Haffele--Grade 11, Matt Miller--Grade 11; Phala Ros-L-Kong--Grade 12, and Hope Williams--Grade 11.

3) Viroqua High School--Media Scholarship Activity Fund Committee.

This group donated $250 unsolicited to the Vernon County Medical Society CHILD SAFE program. The students were also volunteering their time to promote the program and any special events held by the Vernon County Medical Society. The Vernon CMS raised $6,000 for its program and will be distributing a trigger lock to every hunter safety graduates in the county. The group also plans to start an adult hunter safety program. Jason Hohlfelder, a leader of the Media Scholarship Activity Fund Committee and strong safety advocate, was singled out to receive an award of honor.

4) School Students Against Violence of Milwaukee.

This innovative youth group is working with non-violent conflict resolution at North Division High School in Milwaukee. Dr Roberts presented a certificate of honor to Anthony Hibbler, founder of the School Students Against Violence. The 16-year-old has been trained in nonviolence conflict resolution at the King Center in Atlanta and has led conferences, and radio and television programs on using nonviolence in Milwaukee.

5) Positive Youth Development

Another Milwaukee organization dedicated to student enrichment, this important group was also chosen to receive a presidential citation award. A 1995 certificate of honor

was presented to Milele Coggs. Coggs is also a recipient of 1995 Martin Luther King Peacekeeper Award and member of Positive Youth Development. She is a weekly speaker on TV 12's youth program "Teen Forum." She volunteers and is a children's facilitator for African World Festival. In 1994, she was named Miss Juneteenth Day. She is a Safe Night speaker. Milele is the president of the student council at her high school and is a member of the National Honor Society. She is a member of "Positive Youth Development," which is a leadership conference on conflict resolution for freshmen. She serves on the youth conference planning committee for Fighting Back Initiative in Milwaukee County and she is a volunteer tutor with the Homework Help Program at Martin Luther King Library.

Distinguished Service Award

The SMS selected Timothy J. Van Susteren, Ph.D., of the Medical College of Wisconsin, to receive the 1995 Distinguished Service Award for his work to develop and maintain quality continuing medical education in the state. This award is bestowed each year by the SMS to recognize outstanding contributions in the field of medicine by a Wisconsin physician.

Dr Van Susteren currently serves as the director for continuing education for the Medical College where he administers and directs more than 300 educational programs annually for physicians, nurses, psychologists, social workers, administrators and other health care professionals. He is known throughout the state and region as an expert on continuing medical education and adult learning and was elected vice president of the Wisconsin Association of Adult and Continuing Education for 1994-1995.

Dr Van Susteren is also an assistant professor in the Department of Psychiatry and is on the faculty of the Department of Educational Psychology of the University of Wisconsin-Milwaukee. Dr Van Susteren serves as the MCW representative on the SMS Commission on Continuing Medical Education.

Health Leadership Awards

Rep. Mark Meyer (D-La Crosse) and Rep. Frank Urban (R-Brookfield) have earned 1995 Health Leadership Awards.

The Health Leadership Awards are given annually to one or more outstanding persons in government service in recognition of contributions to the development of health care policies that benefit the people of Wisconsin. Among past recipients are US Rep Tom Barrett and former state secretary of Health and Social Services Gerald Whitburn.

Rep Meyer was recently elected to his second term representing the 95th Assembly District which includes most of the city of La Crosse. During Meyer's first term, he served as vice chair of the Assembly Health Committee and also served on the Assembly Aging and Long-Term Care Committee. He was reappointed to both committees for the current session.

Meyer is a strong advocate for tort reform and was a leader among Assembly Democrats in support of a $350,000 cap on non-economic damages, those damages awarded in addition to funds for real medical costs-future and present- in medical malpractice lawsuits. In efforts to improve access to health care, Meyer led legislative efforts in 1994 to ensure that all primary care providers received better Medicaid compensation for providing obstetric and gynecology services in underserved areas.

Rep Frank Urban, MD, has been until recently the sole physician member to serve in the state Legislature. Urban represents the 99th Assembly District, which includes parts of Brookfield and Waukesha County, since 1989. Dr Urban currently serves as vice chair of the Assembly Health Committee. He is a strong supporter of a cap on noneconomic damages and an advocate for public health programs and tobacco prevention. This session Dr Urban is the sponsor of a bill requiring all guns to be sold with trigger locks. Dr Urban has also authored legislation which would create a medical savings account, allowing Wisconsin residents greater flexibility in making health care decisions.

Jim Witalka, of Milwaukee, won the 1995 Health Issues Reporting Award for his coverage of CHILD SAFE, the SMS gun safety program.

Meritorious Service Awards

Each year during the annual meeting, the State Medical Society recognizes leaders in health care who have made significant contributions to the medical profession and to improving the health and well-being of Wisconsin citizens. The Meritorious Service awards are given to physicians and others who have given extraordinary service to the SMS, primarily through their tenure on a commission or committee.

The following individuals earned 1995 Meritorious Service Awards:

- James L. Basiliere, MD, of Oshkosh, for nine years of dedicated service to the SMS Board of Directors and six years of service on the Commission on Environmental and Occupational Health;

- Lloyd R. Cotts, MD, Rice Lake, for three years of dedicated service to the Board of Directors;
- Robert T. Cooney, MD, of Portage, for eight years of dedicated service to the WNA/SMS Liaison Commission;
- Carl S. L. Eisenberg, MD, of Milwaukee, for 11 years of dedicated service on the SMS Commission on Governmental Affairs;
- Jerome H. Gundersen, MD, of La Crosse, for six years of dedicated service on the Commission on Maternal and Child Health;
- James E. Gutenberger, MD, of Madison, for nine years of dedicated service on the Commission on Mediation and Peer Review;
- Jerry M. Ingalls, MD, of Monroe, for his dedicated service as chair of the Task Force on Quality Assessment and six years of service on the Commission on Health Care Financing and Delivery;
- Bruce A. Kraus, MD, of Columbus, for five years of dedicated service on the Commission on Geriatric Health;
- John E. Kraus, MD, of Marinette, for nine years of dedicated service on the SMS Board of Directors;

Changing of the guard. Raymond C. Zastrow, MD, of Milwaukee, (left) congratulates his colleague outgoing SMS Board of Director chair Richard H. Ulmer, MD, for his devoted efforts on behalf of SMS. Dr Ulmer, of Marshfield, is the new president elect and Dr Zastrow now serves as chair of the SMS Board of Directors.

- Richard D. Lindgren, MD, of Madison, for nine years of dedicated service on the Commission on Injury Prevention and Control;
- Thomas J. Luetzow, MD, of Watertown, for nine years of dedicated service on the Commission on Injury Prevention and Control;
- Michael P. Mehr, MD, of Marshfield, for 10 years of dedicated service on the Commission on Governmental Affairs;
- Bernard F. Micke, MD, of Madison, for nine years of dedicated service on the Commission on Governmental Affairs;
- Lyle L. Olson, MD, of Darlington, for 10 years of dedicated service on the Commission on Mediation and Peer Review;
- William E. Raduege, MD, of Woodruff, for nine years of dedicated service on the SMS Board of Directors;
- Thomas A. Reminga, MD, of Milwaukee, for nine years of dedicated service on the SMS Board of Directors;
- Ordean L. Tortstenson, MD, of Madison, for six years of dedicated service on the Commission on Maternal and Child Health;
- Richard H. Ulmer, MD, of Marshfield, for nine years of dedicated service on the SMS Board of Directors;
- Sridhar V. Vasudevan, MD, of Brookfield, for six years of dedicated service on the Commission on Environmental and Occupational Health;
- John D. Wegenke, MD, of Madison, for nine years of dedicated service on the SMS Board of Directors;
- Warren H. Williamson, MD, of Racine, for 11 years of dedicated service on the SMS Commission on Health Care Financing and Delivery;
- Carl Zenz, MD, of West Allis, for nine years of dedicated service on the Commission on Environmental and Occupational Health; and
- Edward Zupanc, MD, of Monroe,

for nine years of dedicated service on the Commission on Continuing Medical Education.

Physician-Citizen of the Year Awards

District 1 -- Nicholas L. Owen, MD, Racine
District 2--Linda Farley, MD, Verona
District 3--Jerome Kitowski, MD, Black River Falls
District 4--Russell A. Dean, MD Greenwood
District 5--John E. Lent, MD and Alfred G. Pennings, MD, Fond du Lac
District 6--Fred Lamont, MD, Green Bay
District 7--Eugene Jonas, MD, Ellsworth

Physician-Citizen of the Year nominees

The following physicians were nominated by members of their communities for the Physician Citizen of the Year Award:

A. Charles Alexander, MD, Racine
James C. Allen, MD, Madison
Maqbool Arshad, MD, Milwaukee
Raymond Bachhuber, MD, Green Bay
Jack M. Bergstein, MD, Milwaukee
Barry Berstein, MD, Milwaukee
John M. Bohn, MD, Middleton
Carol Brown, DO, Milwaukee
David Castleberg, MD, Durand
Donald Cohill, MD, Racine
James P. Daleiden, MD, Waukesha
Robert Dohlman, MD, Durand
Arthur Dorrington, MD, Hales Corners
H. Leslie Ericson, MD, Racine
Louis H. Frase, MD, Eau Claire
Jerry Friedman, MD, Milwaukee
Robert S. Goldman, MD, Milwaukee
Bruce Hanson, MD, New Richmond
Steve Hargarten, MD, Milwaukee
Edgar O. Hicks, MD, Eau Claire
J. Greg Hoffman, MD, Eagle River
James Linn, MD, Milwaukee
William J. Little, MD, Racine
Robert Mead, MD, Green Bay
Marshall J. Mirvis, MD, Milwaukee
Devin Mudge, MD, Racine
David C. Murdy, MD, Janesville
William Rupp, MD, Eau Claire
Frank Springer, MD, Elmwood
Jeffrey C. Thomas, MD, Janesville
Lauree Thomas, MD, Milwaukee

John R. Petersen, MD, of Milwaukee, discusses the finer points of a legislative concern with SMS contract lobbyist Terry Hottenroth (left), of Madison. Hottenroth is a past director of SMS governmental relations and has worked to pass myriad SMS legislative issues.

Houghton Award

The Houghton Award is presented annually to senior medical students who demonstrate scholastic excellence, extra-curricular achievement, and interest in medical organization. Winners receive a check for $500 and an engraved plaque, both of which are presented at the annual meeting. The 1995 winners are: George J. Rhodes, of the Medical College of Wisconsin, and Kevin E. Wasco, of the University of Wisconsin medical school.

Health Issues Reporting Award

Established in 1990, the Medical Issues Reporting Award is presented to the Wisconsin journalist who best covers health care concerns during the preceding calendar year. Criteria for evaluating candidates for this award include quality of writing, depth of research, excellence in production, accuracy, clarity, impact in Wisconsin, fairness and originality.

Jim Witalka and Tom Sutton of WISN-TV in Milwaukee, are the 1995 recipients of the award for medical issues reporting. Witalka and Sutton helped increased public awareness of gun safety issues and provided strong coverage of the SMS Child Safe campaign, a program that has provided more than 10,000 trigger locks to Wisconsin residents.❖

House of Delegates: 1995

State Medical Society of Wisconsin

Speaker: Sandra L. Osborn, MD/Vice Speaker: Michael C. Reineck, MD

County Medical Society	Delegate	Alternate
FIRST DISTRICT		
Kenosha	Steven A Azuma	Spencer J Block
	James L Concannon	Ernesto E Buencamino
	Kevin J Fullin, Jr	Scott R Feldy
	Clifton E Peterson	John C Noonan
Milwaukee	Albert H. Adams	Melbourne D Boynton
	William H Annesley, Jr	John J Eversman
	Anthony H Balcom	Edward S Friedrichs
	Joseph C Battista	Gary S Hauke
	Brian J Bear	Mehran Heydarpour
	Donald R Beaver	George F Kessler
	Gregory B Buck	Michael J. Lynch
	James D Buck	Clifford J Opatken
	Clarence P Chou	William G Raasch
	John M Coffey	Basil M Salaymeh
	Jane M Collis-Geers	Andrew M Satinsky
	Steven K Dankle	Terrance M Scheid
	Donna D Davidoff	Morton M Soifer
	Gerald J Dorff	47 Vacancies
	Jerome W Fons, Jr	
	Reynaldo P Gabriel	
	Charles E Gessert	
	Daniel D Gilman	
	Lucille B Glicklich	
	Gerald G Govin	
	William W Greaves	
	Susan L Kaehler	
	James P Ketterhagan	
	David H Klehm	
	Mahendra S Kochar	
	Vijay V Kulharni	
	George M Lange	
	Peter M Layde	
	Gary J Leo	
	Edith L Lepgold	
	Sanford R Mallin	
	William E Martens	
	Brian P McSorley	
	James A Means, III	
	Dean D Miller	
	John P Mullooly	
	Thomas E Palmer	
	James T Paloucek	
	Jazmin D Parcon	
	Wayman Parker	
	John R Petersen	
	Robert F Purtell, Jr	
	Thomas A Reminga	
	John E Ridley, III	
	George R Schneider	
	Ron H Stark	
	Robert H Straub	
	Thomas A Taft	
	Leon Cass Terry	
	William L Treacy	
	C R Triyambakaraj	
	Frank H Urban	
Milwaukee (continued)	Wess R Vogt	
	Sheldon A Wasserman	
	John E Whitcomb	
	DeLore Williams	
	James E Youker	
	Carol E Young	
	Raymond J Zastrow	
	Vacancy	
Ozaukee	Arthur B Conrad	Gregory J Gnadt
Racine	Mark E DeCheck	Jerome C Brooks
	Dennis J Kontra	S Marshall Cushman, Jr
	Marvin G Parker	Dennis E Feider
	Carol W Potts	Ronald E Schulgit
	Gregory A Shove	Mahmood S Shaikh
Walworth	Irwin J Bruhn	Edsel G Doreza
	Vacancy	Vacancy
Washington	2 Vacancies	William J Listwan
		Thomas E Looze
Waukesha	Robert O Buss	Katherine M Bayliss
	La Vern H Herman	Brian A Chapman
	Charles E Holmburg	John J Foley
	Julie N Larsen	Terrence N Hart
	Timothy G McAvoy	Karin Kultgen
	G Daniel Miller	Kraig E Lorenzen
	Michael G O'Mara	Thomas J Luetzow
	John R Park	Matthew A Meyer
	John D Riesch	Albert J Motzel, Jr
	Jay F Schamberg	Gwendolyn Tanel
	James A Stadler, II	Mark A. Timm
	Lee M. Tyne	Gregory N Van Winkle
SECOND DISTRICT		
Columbia-Marquette-Adams	Robert T Cooney	Martin L Janssen
Dane	Adam H Balin	Christine H Biedermann
	John W Beasley	Haywood S Gilliam
	Thomas H Browning	Judith N Green
	Dolores A Buchler	Susan N Isensee
	Raymond W Chun	John D Kenny
	Andrew B Crummy, Jr	Ivan Knezevic
	Kay A Heggestad	Fred H Koenecke, Jr
	Bruce K Jacobson	Paul A McLeod
	William L Kopp	Bernard F Micke
	Richard D Lindgren	Steven L Oreck
	Bradley L Manning	Joseph F Sackett
	John C McDermott	Alan I Schwartzstein
	John K Scott	Bonnie M Tompkins
	Robert B Shapiro	Roland J Vega
	Richard L Staley	John D Wegenke
	Armond H Start	Anne C Weiss
	Benton C Taylor	Richard O Welnick
	John A Vukich	William A Wood
	7 Vacancies	7 Vacancies

County Medical Society	Delegate	Alternate
Dodge	Ayaz M Samadani	Sharon L Haase
Grant	Dannen D Mannschreck	Kurt Wilhelm, II
Green	Jan E Erlandson	Mark W Kimpel
	George W Kindschi	Robert L Vickerman
Iowa	Harald P L Breier	Timothy A Correll
Jefferson	Michael A Grajewski	Ronald R Liebenow
	Wahab A Kazi	Vacancy
Lafayette	Robert J Bernardoni	Lori L Neumann
Richland	Mark H Brus	Kay Balink
Rock	Mark D Canty	Leland J From
	Kimberly A Kick	Rodrigo Merino-Roldan
	David C Murdy	4 Vacancies
	Larry M Ojeda	
	Jeffrey C Thomas	
	Kathleen M Wick	
Sauk	John A De Giovanni	Donald W Vangor
	Vacancy	Vacancy
THIRD DISTRICT		
Crawford	Michael S Garrity	Vacancy
Juneau	David M Hoffman	Leon J Radant
La Crosse	Wayne A Bottner	Christopher M Huiras
	Gary L Bryant	Paul J Leehey, III
	Thomas J Grau	Charles E Link
	Paul H Steingraeber	Brian M Mulrennan
	Benjamin C Wedro	3 Vacancies
	David E Westgard	
	Vacancy	
Monroe	Kevin A Jessen	Edward O Lukasek
Trempealeau-Jackson-Buffalo	Jeffrey K Polzin	Elmer P Rohde
Vernon	Mark H Andrew	Duane M Koons
FOURTH DISTRICT		
Clark	Demetrio C Maguigad	Florentino E Lleva
Forest	Vacancy	E Frank Castaldo
Langlade	Vacancy	James O Moermond, Jr
Lincoln	Larry A Hooper	Vacancy
Marathon	Kenneth L Day	5 Vacancies
	Kevin T Flaherty	
	3 Vacancies	
Oneida-Vilas	Paul W Grotenhuis	John G Nemcek
	William E Raduege	Dorothy K Nemec
	Vacancy	Gary A Peitzmeier
Portage	John K Paulson	Bradley F Johnson
Price	William E Yanke	Joseph V Richards
Taylor	Michael A Haase	Walter W Meyer
Wood	Richard W Clasen	John D Adolphson
	Richard A Dart	Ali K Choucair
	William J Henry	Abe R Dillon
	Michael J Kryda	Gurdon H Hamilton
	William J Mauer	Larry K Heath
	Robert E Phillips	Mario V Ponce
	Theodore A Praxel	Susan L Turney
	Homer H Russ	2 Vacancies
	Vacancy	
FIFTH DISTRICT		
Calumet	William E Hannon	Badri N Ganju
Fond du Lac	Brian C Christenson	Theodore D Miller
	Elizabeth T Sanfelippo	Harry J Zemel
	David R Weber	
		Vacancy
Green Lake-Waushara	Vacancy	Vacancy
Outagamie	Mark H Beard	6 Vacancies
	Gregory A Johnson	
	Peter V Podlusky	
	3 Vacancies	
Waupaca	Joseph W Weber	Terry L Hankey
Winnebago	George W Arndt	Johan A Mathison
	James L Basiliere	6 Vacancies
	James L Cauley	
	Kevin F Quinn	
	L Thomas Rozum	
	James P Siepmann	
	Vacancy	
SIXTH DISTRICT		
Brown	James M Berner	Thomas J Halloin
	Diane K Christel	James V Lacey
	Richard D Horak	Michael G Medich
	Rolf S Lulloff	6 Vacancies
	Wesley E McNeal	
	James E Memmen	
	3 Vacancies	
Door-Kewaunee	John J Beck	Vacancy
Manitowoc	Edward J Barylak	Thomas K Perry
	Joseph C Di Raimondo	Joseph E Trader
Marinette-Florence	Karen B Himmel	Vacancy
Oconto	William J Wittman	James J Wallace
Shawano	Patricia J Stuff	Vacancy
Sheboygan	William P Chleboard	James R Pawlak
	John R Hron	3 Vacancies
	Roger G Klettke	
	Wendelin W Schaefer	

County Medical Society	Delegate	Alternate
SEVENTH DISTRICT		
Barron-Washburn-Burnett	Donald E Riemer	Douglas J Raether
Chippewa	Gerald A Gehl	Philip A Swanson
Eau Claire-Dunn-Pepin	Philip J Happe Charles V Ihle Daniel F Johnson Daniel L Johnson James J O'Connor Henry J Simpson	Robert J Fabiny 5 Vacancies
Pierece-St Croix	Clifford C Tenner	Leonard Torkelson
Polk	John O Simenstad	William W Young
Rusk	Douglas M De Long	Vacancy
EIGHTH DISTRICT		
Ashland-Bayfield-Iron	Mark K Belknap	John C Oujiri
Douglas	Robert L Sellers	Vacancy
Sawyer	Kathy J Keimig	Andrea J Carroll

SECTIONS	Delegate	Alternate
Allergy & Clinical Immunology	Donald A Bukstein	Steven H Cohen
Anesthesiology	Edwin L Mathews	Jose A Villacrez
Cardiology	Vacancy	Vacancy
Dermatology	Donald J Miech	Stephen E Hoy
Emergency Medicine	Dean T Stueland	Peter J Holzhauer
Family Physicians	George L Gay, Jr	Thomas H Peterson
Group Practice	Philip J Dahlberg	Vacancy
Hospital Medical Staff	Paul A Wertsch	Masood Wasiullah
Internal Medicine	Vacancy	Vacancy
International Medical Graduates	Avadh B Agarwal	Juanito P Singson
Long-Term Care	Bruce A Kraus	Richard S Kane
Medical Faculties	Vacancy	Vacancy
Medical Students - MCW	Timothy A Crummy	David R Stolpman
Medical Students - UW-Madison	Stephanie E Wojtowicz	Raymond J Kotwicki
Neurology	Gamber F Tegtmeyer, Jr	R Clarke Danforth
Neurosurgery	Thomas A Lyons	Vacancy
Obstetrics-Gynecology	Dennis A Sobczak	Patricia A Barwig
Ophthalmology	Jack L Hughes	Gregory P Kwasny
Orthopedics	James A Rydlewicz	Vacancy
Otolaryngology	Glenn M Seager	Thomas W Grossman
Pathology	Ronald R Martins	Raymond C Zastrow
Pediatrics	Carl S L Eisenberg	Vacancy
Physical Medicine & Rehabilitation	N M Reddy	Keith B Sperling
Plastic Surgery	Andrea S Doermann	Vacancy
Preventive Medicine	Henry A Anderson, III	Jane K Sliwinski
Psychiatry	Kenneth I Robbins	Vacancy
Radiation Oncology	Sally M Schlise	J Frank Wilson
Radiology	Timothy T Flaherty	Vacancy
Resident Physicians	Heather L Flanery	Anne I Zeni
Surgery	James P Quenan	Rodney W Malinowski
Thoracic Medicine	Pamela A Wilson	John P Schilling
Urology	Thomas W Wood	Randle E Pollard
Young Physicians	Edwin M Overholt, II	Vacancy

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A CESF guide to gifts

Gifts to the foundation may take a number of forms: cash, bequests, trusts, life insurance, real estate, stock or other securities--some physicians are making the foundation a beneficiary of their wills. Such gifts may be designated as unrestricted or for specific immediate use at the discretion of the foundation trustees. They may also be restricted or earmarked for specific purposes of interest to the donor. Likewise, these gifts may also be designated for permanent investment with only the income used to support foundation programs.

The foundation currently asks for a voluntary donation of $70 from the SMS membership through the membership dues statement and other direct mail solicitations.

Contributions provide financial aid to Wisconsin students of medicine and allied health professions, stimulates research into areas of medicine and public health and promotes the preservation of medical history.

Cash gifts. Most gifts received by the foundation are in the form of cash, and personal checks are made payable to the CES Foundation. These gifts, as well as others, may be designated in honor of a relative, friend or associate. The foundation maintains a memorial program which gives the donor an opportunity to remember someone through a gift to the foundation--a living memorial. A memorial card is sent to the family with the name of the deceased and the name of the donor. The donor will receive a card thanking them for their contribution.

Bequests. A bequest is the giving of property by will. The will is designed to assure that upon death the property is distributed exactly in accord with the donor's wishes. One of the purposes of a will can be to perpetuate the donor's name or that of a friend through an organization such as the CES Foundation.

A codicil is an amendment or revision of a previously executed will. An attorney can draft it with minimal cost should donors wish to add a bequest to the CES Foundation to their will.

Gifts of life insurance. Life insurance offers an easy means to make a substantial gift as well as to provide tax advantages for the donor. The CES Foundation is pleased to offer the Endowment Plus irrevocable insurance program which is underwritten by Transamerica Assurance Company.

With a one-time gift or pledge payment agreement over five years--donors agree to let the CES Foundation purchase an endowment life insurance policy in their name. The CES Foundation will own the policy and be the designated beneficiary.

The contribution is fully tax deductible and there are no personal or medical questions asked and no physical exam is required. For annual gifts as low as $500, a substantial endowment can be created in your name. This insurance concept is a wonderful way to build an endowment for the future needs of the CES Foundation.

Real estate. Any standard form of warranty deed or acceptable quit claim deed may be used to deliver real estate to the foundation.

Stock or other securities. Current gifts may take the form of stock or other securities which have appreciated in value. Gift of appreciated securities permit the donor to realize substantial tax advantages.

Personal property. Some donors prefer to make gifts of art, jewelry, antiques, rare books, furniture, or collectibles of other types such as stamps, coins, etc. For tax purposes, the donor must determine the value of a personal property gift on the date of its transfer to the foundation.

Trusts. Some find it advantageous to make a contribution to the foundation, but retain the income from the contribution for the duration of their life or the lives of others. There are important tax advantages to these arrangements. The trustee of such "living trusts" may be a bank, trust company or the foundation.

Among the several types of "liv-

ing trusts" are: annuity gifts; pooled income gifts; unitrust gifts, deferred payment gift annuities, revocable life income plans.

Pooled Income Fund. The CESF is pleased to announce the establishment of a Pooled Income Fund which currently has four donors in the fund for a total of $49,000. This planned giving opportunity permits the donor to combine the advantage of bequests and lifetime gifts in one package. The gift is commingled with other similar gifts which are held in a fund; hence the name "pooled".

Participants and/or their beneficiaries will receive interest income throughout their lives. Upon the death of the investor's last beneficiary, the CESF will receive the principal to reinvest or use for whatever purposes.

If you are interested in the Pooled Income Fund, you are urged to contact your legal adviser, accountant, or Julie A. Hein in the CESF office at 257-6781.❖

CESF facts

The SMS Charitable, Educational and Scientific Foundation is a non-profit, non-stock Wisconsin corporation, chartered in June 1955. As stated in the by-laws, the foundation's purpose is to "engage in, assist, and contribute to the support of charitable, educational, and scientific activities and projects and to contribute to the support of, and to create and maintain, charitable, educational, and scientific institutions, organizations, and funds of any and every kind.

Management. The foundation's governing power is vested in a board of trustees composed of directors and officers of the SMS, other medical and non-medical members elected by the board of directors and one representative elected by each component medical society. Non-medical members may be elected from time to time by the SMS Board of Directors, but the number of such trustees shall not at any time be less than five or more than ten.

The board of directors of the corporate trustees consists of 18 members including the president, vice president and treasurer of CESF, and in addition, 12 members, seven of whom may be non-medical trustees, each elected for staggered three year terms.

Registration. The foundation is registered with the Secretary of State as a charitable organization for purposes of contributions and fund-raising under §440.41(2) of the Wisconsin Statutes.

Legal. The foundation retains Robert B.L. Murphy of the firm Murphy & Desmond, SC, 2 E Mifflin St, Madison, WI 53703; 608-257-7181, for advice on legal and tax matters. Ms. Julie Ann Hein serves as the managing director who works directly with the executive vice president and deputy executive vice president of SMS and is responsible for all duties of the foundation.

Tax Information. Contributions to the CES Foundation are tax deductible under both state and federal tax laws. The foundation is a 501(c)(3) non-profit corporation. As in all matters relating to your financial affairs, the valuation, form and tax aspects of gifts, to the foundation should be discussed with your attorney, accountant or other advisor.

Officers

President: Stephen B. Webster, MD, LaCrosse
Vice president: Kenneth M. Viste Jr, MD, Oshkosh
Treasurer: Rockne G. Flowers, Stoughton
Secretary: Thomas L. Adams,* Madison
Finance Committee chair: Rockne G. Flowers, Stoughton
Assistant treasurer: John K. Scott, MD, Madison

Directors

Betty J. Bamforth, MD, Madison
David K. Falk, MD, Madison
Rockne G. Flowers, Stoughton
Michael S. Garrity, MD, Prairie du Chien
Julie A. Hein,* Madison
Donald J. Heyrman, MD, Menomonee Falls
Pauline M. Jackson, MD, La Crosse
Russell F. Lewis, MD, Madison
Robert B. L. Murphy, Madison
Marcia Richards, MD,* Milwaukee
John Suby, CPA, Madison
Eric Temte, Prairie du Chien
Earl R. Thayer, Madison
Janet Treacy, Waukesha
Richard H. Ulmer, MD, Marshfield
Ronald G. White, Madison

*ex-officio

Staff

Managing Director: Julie A. Hein, Madison
Administrative Assistant: Jane Anderson, Madison
Donor Records: Sandie Robb, Madison❖

CESF history

The Charitable, Educational and Scientific Foundation was chartered by the SMS in 1955 as a non-profit, non-stock corporation to enable physicians and other friends of the profession to support, through gifts and grants, projects vitally affecting scientific medicine and public health. The foundation's scope of interest has grown because of bequest contributions; therefore, a number of worthy programs affecting medical education and health care needs in Wisconsin can be accomplished. The future of the foundation holds an array of opportunities and challenges.

Benevolent assistance. The CES Foundation is ever sensitive to the needs of people who are the victims of adversity. Although the foundation's capacity in dollars has been limited, it has often been able to arouse the spirit of caring among physicians and the public when special needs arise. Assistance is looked at as an investment in the future and not as charity.

Education. Funding from the foundation's Barbara Scott Maroney Memorial Fund for Research on Diabetes support special research projects, summer camp scholarships for diabetic children, publication of scientific articles or presentation of scientific speakers on the subject.

The foundation makes grants available to organizations striving to stimulate student interest in science and expose them to wide varieties of science related careers. Annually, the CES Foundation recognizes outstanding achievements in student science research by high school and middle school students in Wisconsin through contributions for awards to the Wisconsin Science Congress and the Wisconsin Science Olympiad.

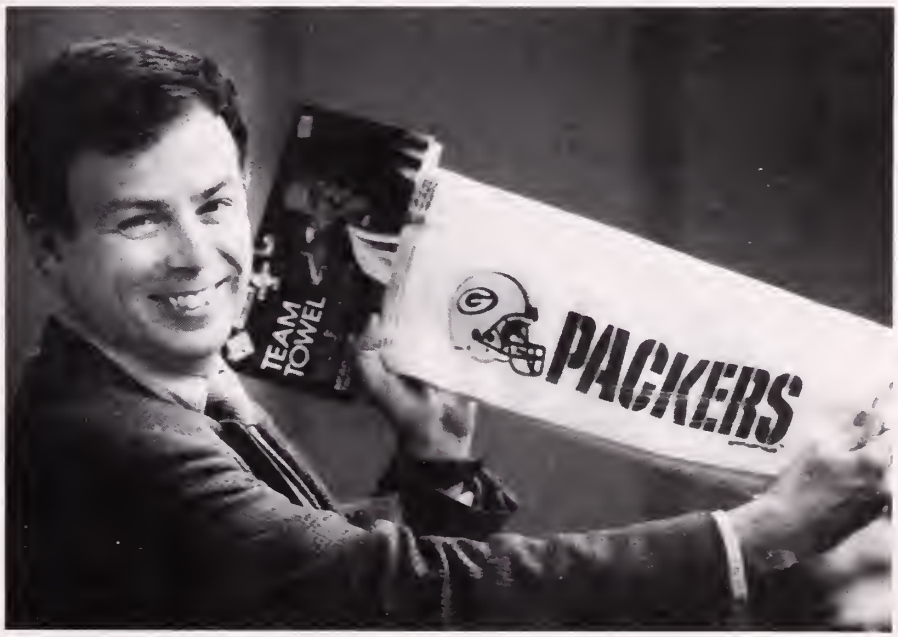
As a project of the county auxiliaries, the Workshop on Health, a health education program for high school students, has featured such topics as anorexia nervosa, eating disorders, sexually transmitted diseases, teen suicide, alcohol and drug abuse, and wellness. Lastly, the foundation has helped to sponsor the "Hands on Health" exhibit at the Madison Children's Museum.

Student loans, grants and scholarships. One of the most important activities of the CES Foundation is the student loan program. Established in 1955, the foundation's general student loan fund is designed to assist needy, deserving students preparing for careers in medicine, dentistry, pharmacy, nursing, and other allied health fields. Long-term, low-interest loans are interest-free until after the student graduates. Personnel in the financial aid departments of Wisconsin medical schools cooperate with the foundation in identifying needy and deserving students.

Many young men and women can achieve their medical careers only because of the availability of low-interest loans. In fact, the average medical student today can anticipate graduating with debt obligations ranging from $50,000 to $75,000. Through fiscal year ending June, 1995, the foundation granted 67 loans to medical and allied health students for a total of $174,000. Repayments during fiscal year 1994-95 totalled $117,342.50. Since the loan fund was established, 1367 students have received $2,160,648 in long-term, low-interest loans.

Although the foundation's primary emphasis is in loans, some outright scholarships and grants are made to fulfill the wishes of some donors and the needs of certain potential recipients. These special health career student loan and scholarship funds are administered by the foundation according to the wishes of the individual or organization establishing and supporting the fund.

The Edward W. Vetter, MD Medi-



Tim McAvoy, MD, displays the door prize he won at the CESF reception, held on behalf of the Charity Golf Classic featuring Packer great Ray Nitschke.

cal Education Scholarship Fund has been established for medical students in all specialty fields of medicine.

Nelson Industries provides a scholarship to an outstanding medical student from an area in which their plant facilities are located.

The Amy Louise Hunter-Wilson, MD Scholarship has been established to assist American Indians who pursue training or advanced education as doctors of medicine, nurses, technicians or in a related health field.

Each year at the SMS Annual Meeting, the CESF awards two Houghton scholarships for the outstanding senior at the University of Wisconsin-Madison Medical School and the Medical College of Wisconsin.

Applications may be procured from the CES Foundation, 330 E Lakeside St, Madison, WI, 53715; or the medical college's financial aids offices. The CES Foundation furnishes an annual accounting to the benefactor or sponsoring organization.

To inquire how you or your organization can establish a special student loan or scholarship fund, contact Julie A. Hein, 330 E Lakeside St, PO Box 1109, Madison, WI 53701; or phone 608-257-6781 (Madison area) or toll-free in Wisconsin 1-800-362-9080.

Wisconsin Association of Senior Physicians. This group was formed in fall of 1980 with the premise of planning and implementing ways in which retired physicians can continue to be a part of the advances and progress of medicine. The staff of CESF coordinates meetings and programs that are held in the spring and fall each year.❖

Foundation grant allocation

THANKS TO THE EFFORTS of a tremendous number of physicians, the foundation is supporting a greater number of programs on a broader spectrum.

The list of grants provided by the foundation during this past year spells substantial achievement. Through physician support and leadership, the foundation hopes to encourage similar support from others. With education as its vanguard, the CESF prides itself in supporting medical education, research and history programs.

During 1994, the foundation contributed to a number of worthy projects through unrestricted and restricted contributions:

- Wisconsin Junior Academy to support Wisconsin Science Congress for high school research projects;
- Volunteer Braillists & Tapists, Inc.;
- *Wisconsin Medical Journal* medical student writing contest;
- Madison Children's Museum to sponsor an exhibit entitled, "Hands on Health";
- Barbara Scott Maroney Fund to sponsor a lecture on diabetes;
- Wisconsin Public Health Association for awareness week and centennial;
- Wisconsin Research Network conference;
- UW Department of Medical Microbiology & Immunilogy for a research project;
- Wisconsin Safety Patrols, Inc. to sponsor the trip to Washington DC
- Marathon County Medical Auxiliary to sponsor a family violence conference; and
- J.G. Crownhart Memorial Fund for the *WMJ* July issue.

For further information regarding the CES Foundation, please contact Julie A. Hein, CES Foundation, PO Box 1109, Madison, WI 53701; 608-257-6781. ❖

The Fort Crawford Medical Museum

The Fort Crawford Medical Museum is unique among educational institutions. Far more than a museum, it stands as a tribute to Wisconsin's physicians who have dedicated their lives to ensuring the health of the state's citizens.

The Fort Crawford military hospital has been designated a national landmark, and is located in Prairie du Chien near the Mississippi River. On this site in the 1830s, Dr William Beaumont carried out his famous experiments on the physiology of digestion.

The actual planning for the museum began in the 1930s when the SMS placed a granite memorial near the crumbling remains of the second Fort Crawford, which had been abandoned in 1872.

The property was deeded to the SMS Charitable, Educational and Scientific Foundation in the 1950s, and the SMS approved the completion of the museum complex. In 1962, the Stovall Hall of Health was added, in honor of Dr William Stovall to provide additional exhibit space.

The museum houses relics of nineteenth century medicine in Wisconsin, including displays of Indian herbal remedies, a drug store, and dentist and physicians' office.

The museum is open Wednesday through Sunday, 10 am to 5 pm, May 1 through Oct 31.

In 1981, the Fort Crawford Medical Museum Endowment Fund was established to provide financial support for the museum. Over the years, more than 200,000 visitors have toured the museum, yet it continues to face financial hardship and is in need of frequent repair.

Named in honor of Dr William Beaumont, the fund has received over $165,000 from a select group known as the Beaumont 500. With a gift or pledge of $1,000, donors receive a specially designed Beaumont medallion.

The goal is to build a trust fund of 500 contributors or $500,000 in monies. The fund is earmarked to provide for the staffing, utilities, repairs and maintenance, new exhibit construction and renovation, and museum promotion.

A future goal is to develop a contemporary medical exhibit that would incorporate healthcare issues.

For more information about the Fort Crawford Medical Museum, please contact Julie A. Hein at the CES foundation at 800-362-9080 or (608) 257-6781.

Beaumont 500 members:

1980
Pierce-St Croix County Medical Society

1981
Mr and Mrs Robert B. Murphy
Guy W. Carlson, MD
W. Bruce Fye, MD
Pauline M. Jackson, MD
Dr and Mrs William D. Janssen
Dr and Mrs T. A. Leonard
E. J. Nordby, MD
Karver L. Puestow, MD
John D. Riesch, MD

1982
anonymous
Marion Crownhart
E. M. Dessloch, MD
Melvin F. Huth, MD
Michael F. Ries, MD
E. A. Steffen, MD
Kenneth M. Viste, Jr, MD

1983
W. Bradford Martin, MD
Earl R. and Alice Thayer

1984
Dr and Mrs K. Alan Stormo
Dr and Mrs Chesley Erwin
Dr and Mrs Leonard B. Torkelson
Leland C. Pomanville, MD
Mrs W. D. Hoard
Dr and Mrs Ralph Hudson

1985
Dr and Mrs Roger von Heimburg
Dr and Mrs Bertram H. Dessel
Mace Garrison Zinggeler
Dr and Mrs Benjamin Brunkow
Robert T. Cooney, MD
Staff of the State Medical Society of Wisconsin

1986
Dr and Mrs William Listwan
Richard W. Edwards, MD
Amy Hunter-Wilson, MD
Kari, Doran and Kenneth Viste
Roy Selby, MD

1987
Sandra Osborn, MD
Timothy T. Flaherty, MD
Washington County Medical Society
Dr and Mrs Roland R. Liebenow
Racine County Medical Auxiliary
State Medical Society of Wisconsin

1988
Jefferson County Medical Society
Milwaukee County Medical Auxiliary
Milwaukee County Medical Society
Dr and Mrs Victor Wong
Physicians Insurance Company of Wisconsin
Dr and Mrs Ken Smigielski
Kenneth M. Viste, Jr, MD, in honor of the SMS staff
Joan Flaherty
Edward A. Burg, Jr, MD, family
SMS Services, Inc

1989
Dr and Mrs Stephen Webster
Dr and Mrs Kermit Newcomer
Sauk County Medical Society
Wood County Medical Society
Dr and Mrs John D. Wegenke
La Crosse County Medical Society Auxiliary

1990
Green County Medical Society
Winnebago County Medical Society Auxiliary
Dr and Mrs Louis Hacker

1991
Brown County Medical Society Auxiliary
Dr Robert and Roberta Baldwin
Cyril M. Hetsko, MD and Theresa M. Hottenroth
Dr and Mrs J D Kabler

Continued on next page

Continued from previous page
State Medical Society of Wisconsin Auxiliary
1992
Columbia, Marquette, Adams Medical Society
Dane County Medical Society
Eau Claire, Dunn, Pepin Medical Society Auxiliary
Fond du Lac County Medical Society
Fond du Lac County Medical Society Auxiliary
Dr and Mrs Gerald C. Kempthorne
La Crosse County Medical Society
Patricia J. Stuff, MD
Vernon County Medical Society
Waukesha County Medical Society Auxiliary
Dr and Mrs David Weber
Winnebago County Medical Society
Dr and Mrs Raymond C. Zastrow
1993
Dr and Mrs Joseph C. DiRaimondo
Marathon County Medical Society
Richland County Medical Society
Dr Robert and Laura Roberts
Dr Ken and Jan Viste
1994
Charles Pechous, Jr., MD
William Young, MD
Beaumont 500 pledges
Thomas and Diane Adams
Manitowoc County Medical Society Alliance❖

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All manuscripts will be edited by the *Journal* staff for clarity, organization, grammar, spelling, and punctuation, and in accordance with AMA style (*AMA Manual of Style*, 8th ed, and *AMA Manual for Authors and Editors*). Suggestions for titles are welcome, but are subject to the constraints of clarity, space, grammar and style.

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- Typed manuscripts must be submitted in triplicate (one original, two photocopies). Type on one side only of standard-sized white bond paper, using 1-inch margins. Double-space throughout.
- Organization for scientific papers:

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Results—Provide results in the test, tables or illustrations. If tables or illustrations are used, emphasize or summarize only the most important observations in the text.

Discussion—Discuss the conclusions that follow from the results, as well as their limitations and relations to other studies. Show how the conclusions relate to the purpose of the study. Recommendations, when appropriate, may be included.

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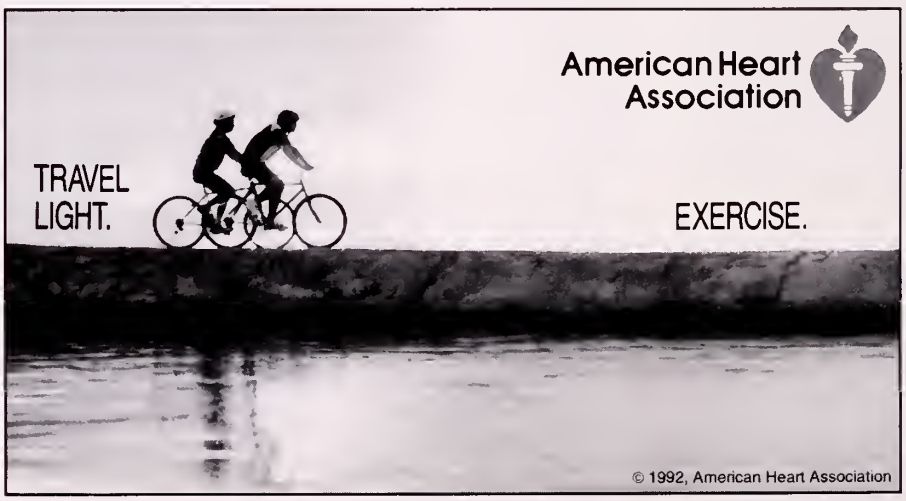

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Call For Papers

Uncertain Times: Preventing Illness, Promoting Wellness

1996 International Conference on Physician Health

February 8-10
Chandler, Arizona

Authors are invited to submit abstracts for consideration as part of the 1996 International Conference on Physician Health, which is sponsored by the American Medical Association, the Canadian Medical Association, the Federation of State Medical Boards, and the Federation of Licensing Authorities of Canada.

Presentations dealing with any aspect of physician health, including issues of well-being, impairment, disability, treatment, and education are welcome. Of particular interest are:

- Coping with changing economic or practice circumstances
- Stress and physician health
- Epidemiologic data
- The effects of violence directed at physicians
- Violence occurring within physicians' families
- Patient exploitation
- Mental illness, including substance abuse
- Physical illness and disability
- Special populations
- Comparative data across states or countries
- Physician well-being and family functioning
- Updates on clinical areas (depression, pharmacotherapy, etc.)

Three types of presentations are welcome:

- Poster presentations: written presentations of data-based research
- Paper sessions: Oral presentations of scientific, data-based findings on issues of physician health. Paper presentations will be grouped into related panels, with individual papers presented in 20 minute time slots
- Workshops: Training or instructional presentations designed to improve the skills and knowledge of persons working in the physician health field

Abstracts for all presentations must be submitted on the abstract submission form which is available from: American Medical Association, Physician Health Program, Attn. E. Tejcek, 515 North State Street, Chicago, IL 60610.

All presenters must register for the conference and will pay the AMA member rate. Presenters will be responsible for their own expenses.

Deadline for submission is October 2, 1995

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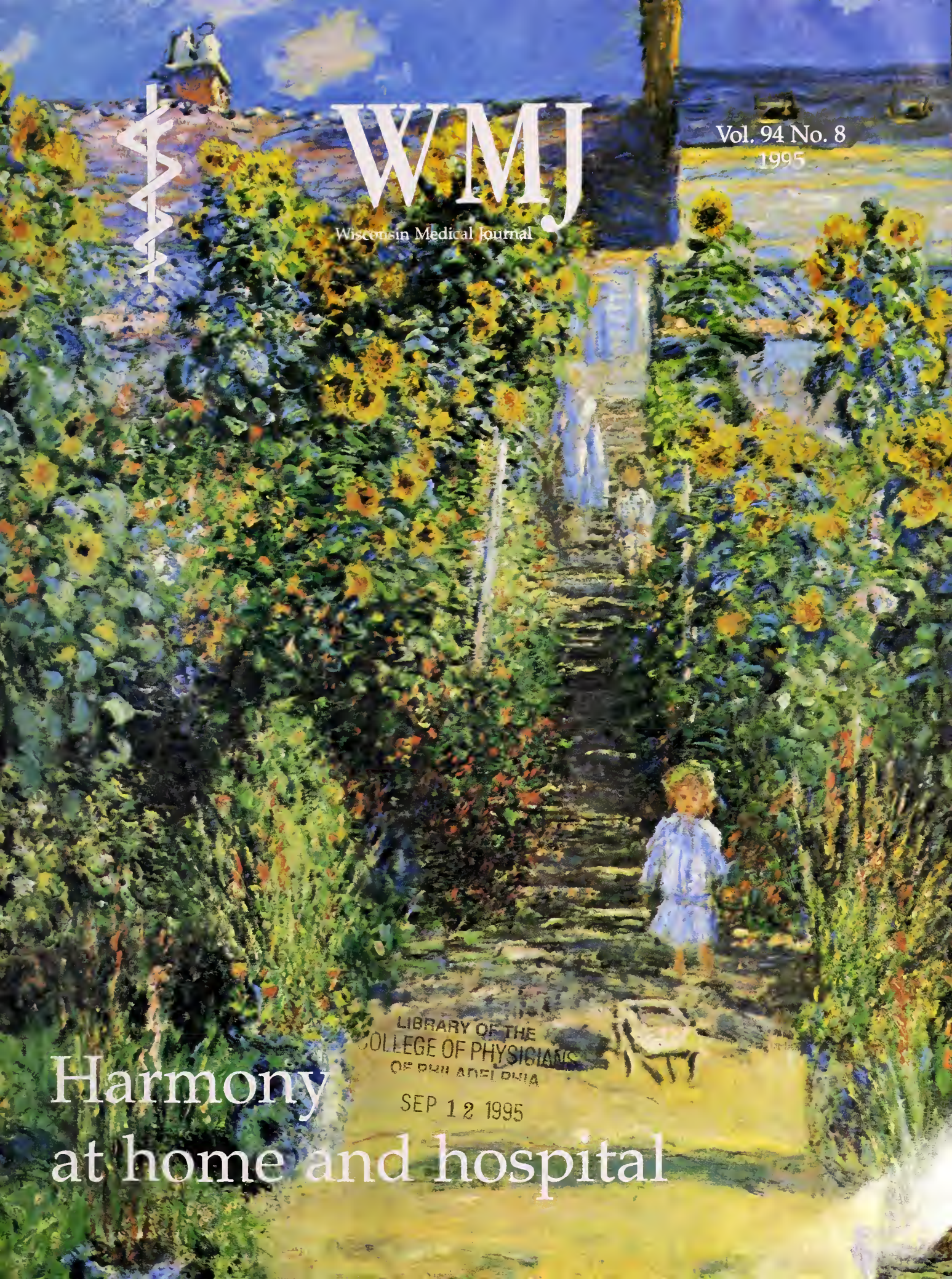

WMJ

Wisconsin Medical Journal

Vol. 94 No. 8
1995

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Our cover: Harmony thrives in Claude Monet's The Artist's Garden at Vetheuil. Related cover stories on pages 455 and 464.

Wisconsin Medical Journal

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President's page
Medicine, money, and morality...

"Competition brings out the best in products and the worst in people"
--David Sarnoff

Marcia J. S. Richards, MD

MANAGED COMPETITION IS promoted as the miracle solution to rising health care costs. But with application of managed care, the great broadcaster and business guru Sarnoff would predict potential human problems on the horizon for physicians. It's apt that we should heed the age-old advice; that being forewarned, we can be prepared.

For us as physicians, we can limit our potential ethical transgressions if we are prepared for, and perceptive of, potential problems on this new dawn. Surfing successfully through managed care is kind of like skiing. You are more likely to stay upright if you can see the landscape ahead.

The most serious potential new conflicts of interest, I believe, are created by financial incentives for the provision of less care to patients. If we only cut out what may be excessive or ineffective medical care, managed competition will yield a better product, as Sarnoff suggests. But usually when a pendulum swings, it first sways too far to the other side before it begins to list back toward the middle and, eventually, finds equilibrium.

Fully cognizant of this likelihood, the medical profession must ensure that safeguards are in place to protect our patients and the doctor-patient relationship. To this end, the AMA Council on Ethical and Judicial Affairs has published a report.[1] (Please note: I believe this report is vital reading for all physicians! You need to read this.) In addition, our own state society has established policy on a number of issues relative to managed care.[2]

As president, however, there are a few specific issues that demand thorough consideration and cause me (and others) major concern.

I suspect that no one among us doubts that health care dollars will be allocated far more stringently in the future than in the past. Decisions will have to be made to determine which patient with which diagnoses receives which procedure(s) at what cost to society and the bottom line. We should not allow ourselves to be asked to haphazardly make rationing decisions at the bedside, based on financial guidelines or goals. It creates too great a conflict with the physician's primary role as healer.

Rather, we must insist instead that these decisions be made prospectively--based on solid scientific data and shaped by predominant physician and societal thought. These decisions should then be set into clear, readily available policies. (There are already examples of this type of decision-making occurring in other states and by our own state's Medicaid Medical Audit Committee, a physician review panel.)

If the organization or plan in which we participate does not allow an accepted treatment option, we physicians must ensure that we are still free to advise patients of alternatives not covered and accompany them through an appeal process--if we or they choose. Furthermore, we

Continued on next page

must set in place safeguards so we may follow an appeal without risk of recrimination by the managed care organization to either our patients or ourselves.

On to the root of most evil: the love of money. Financial incentives for physicians should be constructed to reward cost effective, high quality health care and should not be awarded based on the withholding of medically necessary care. These incentives should be required to be disclosed to the patient. This is especially important since research by The Advisory Board Company has demonstrated that the most effective method of reducing medical costs is to make the individual primary physician responsible for all costs of care for their patients (full personal capitation.)[3] They wisely caution, however, that safeguards must be in place to be certain that care is not compromised.

As physicians we need to ensure that potential financial conflicts of interest are not born singularly by a physician, but are overseen by a group of responsible physicians. We must not allow such new methods of physician reimbursement to put us as individual physicians between the insurer and care for our patients. This is not to say that financial incentives relative to patient care have not always been a part of medicine, but in the American tradition, where more of anything is usually better, incentives to limit care are more problematic.

These are but a few of the ethical crevasses on the horizon, many of which will be addressed by the SMS Commission on Medicine and Ethics over the next year, as part of our effort in responding to physician and patient advocacy issues presented by managed care.

Please let your views be known. Get involved locally, regionally and nationally. We need your expertise.

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EVP report: The view from here
Restructuring Medicare or resurrecting the lost covenant

A journey of a thousand miles must begin with a single step.
--Lao-tzu

LAST MONTH we focused on the need for medicine to avoid turf wars and unite around proposals to successfully correct deficiencies in our health care delivery system.

Today more details of the latest AMA proposals are available and I'd like to set them before you now, keeping you up to speed on what's happening on the national scene. This way, you can be a real part of the democratic process by voicing your reactions to the national proposals--and helping to identify strengths and weaknesses--to your representatives within medicine.

The plan I'm about to outline for you should not by any means be regarded as a final document. Rather, it is our first step on a "1000-mile journey" to restructure Medicare. All of the steps along the way will have to be chosen carefully. Since most of us are not physically making the journey ourselves, it is up to us to provide the directions and the encouragement our designated travelers will need to complete a successful journey. (See delegate names and telephone numbers in sidebar.)

Through your active participation, the final products endorsed by medicine will truly reflect the voices of all physicians. By choosing to lobby your delegates in organized medicine--rather than your congressional delegates--at this time, you are enabling medicine to maintain a strong front as a house united before Congress.

The AMA's proposal to restructure the critically ailing Medicare is nothing if not innovative. What makes this plan so exciting is that it actually succeeds in the marriage of improving health care quality and reducing delivery costs. (Others, you will remember, have tried unsuccessfully to implement these laudable goals. The most prominent, of course, was President Clinton, and you'll remember his attempts were met with unsubstantiated allegations that, perhaps, he'd begun inhaling.)

Thomas L. Adams, CAE

Nonetheless, this plan seems to actually have done it--by empowering Medicare consumers and putting the decisions back in their hands, limiting involvement of bureaucrats.

So how would this Medicare restructuring plan work? Under medicine's proposals, a Medicare beneficiary would have two options, either to:

- stay in the traditional Medicare reimbursement system (which would be left much the way it is today), or

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- join a system like the successful, cost-effective Federal Employees Health Benefit Plan (FEHBP). With this option, Medicare enrollees would be able to purchase coverage at any level in any form--from traditional insurance to an HMO to a catastrophic plan coupled with a medical savings account.

For those choosing to remain in the traditional Medicare setting, there would be three changes:

- individuals would meet a preset yearly deductible; after that all costs would be paid by Medicare (The proposal exempts cost sharing for those with incomes at or below the poverty level and provides a sliding scale for those with incomes at or below 150% of poverty level);
- there would be no need to purchase medicap insurance; and
- prices for services would no longer be fixed by the Medicare program. Medicare would continue to reimburse providers a predetermined amount for a particular service. Then based on the price charged by the provider the Medicare patient chose to see, he or she would either save money or pay the balance to the physician.

For those who opted into ""Medichoice," the second, non-traditional Medicare option, they would be credited with the dollar amount they would have received under regular Medicare and would be free to purchase any coverage they desire, enhancing both cost consciousness and provider competition.

The AMA proposal demands our attention because independent analysis by Price Waterhouse estimates scorable savings of $162.2 billion over a 7-year time frame, in addition to improving the quality of care for Medicare recipients. Additionally, the plan seeks to raise Medicare's eligibility age over time so that it is consistent with Social Security and slightly reduces the Medicare subsidy of high income beneficiaries.

By implementing these and other changes and empowering Medicare beneficiaries to choose their physicians, health care plans and courses of treatment, we believe this plan will lay the foundation for a stronger, healthier health care system for our nation's elderly. I encourage you to speak with your delegates about the plan, ask questions and get involved in the developmental process.

The transformation envisioned here will require the understanding and support of all players. Let's examine this proposal thoroughly, fine-tune it to make it stronger and show America that physicians are indeed concerned with the greater good of all. It's our time to shine; let's take that first step.❖

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Letters

Torte reform battle rages

To the editor: On the cover, a photo of a handshake of treaty; in the EVP report an "...era of torte wars...coming to a close"; in United We Stand,"...genuine torte reform completed its long and tortured path..."; in the letters, "...have finally succeeded in reaching the top of the torte reform mountain."

Perhaps the champagne has flowed too liberally. The torte wars are not over, torte reform is not complete, and we are far from the top of the mountain. We have achieved a very significant victory, and indeed can rejoice in that. We have won a battle, but the war rages on. Let's make the celebration brief, and not lose sight of the asinine antics that will continue in the malpractice proceedings across our nation, until total torte reform is accomplished.

--Geoffrey C. Kloster, MD
Diplomat ABFP
Galesville Medical Clinic❖

Milwaukee responds

To the editor: In response to the letter from D. Mark Lochner, MD,[1] who expressed his opinion on the recent decision to not move to a single statewide Medicare payment district, the Medical Society of Milwaukee County would like to point out that practice overhead is higher in urban areas than in rural areas. The geographic adjustment factor utilized by Medicare to determine payments recognizes this fact.

To quote from our May 11, 1995, letter to Bruce Vladeck, Administrator of HCFA:

The appropriate way to equalize Medicare payments in Wisconsin would be to raise the payment rates in those areas that now feel they are not being fairly compensated. To reduce already low Medicare payments to urban practices with high overhead costs makes no sense.

We support a fair reimbursement rate for all Wisconsin physicians.

--William W. Greaves, MD, MSPH
President
The Medical Society of Milwaukee County

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Managed care misfires

To the editor: The recent pattern of managed care companies selecting individuals within groups to be providers is an anathema to good clinic function. The job of assigning therapists then requires an additional level of screening, the chance of finding a timely open appointment decreases. Scheduling bottle necks result with some providers being over crowded one week and empty the next while the opposite is occurring in the next office. Patients become upset with delays in treatment. Unfortunately, they focus their anger on the unavailable provider rather than their controlling insurance company.

A recent experience with (the company's name) refusing to credential our new AODA therapist (masters level, greater than five years experience, glowing letters of recommendation) because she "isn't a good fit" has been, for me, the last straw. My offers of extra supervision and documenting patients satisfaction were dismissed. The acting administrative head of the Milwaukee office stated the rejection had nothing to do with clinical competence. To me this represented the worst of the old fraternity system with this therapist black balled for not "fitting in."

Managed care has never been acclaimed for its humanity. (The company's name) arbitrary provider roulette is frankly inhumane.

--Peter C. Joosse, MD
West Bend

Editor's note: Examples of managed care concerns are helpful in developing policy. Others with examples are encouraged to share their experiences. ❖

Malignant gastroesophageal polyp: a case report

Daniel G. Cavanaugh, MD; Leland D. Crandall, MD; Les P. Harrison, MD; John H. Layer, MD; and Ronald K. Waits, Jr, MD, Chippewa Falls

This case illustrates the entity of esophagealadenocarcinoma presenting in an esophageal polyp. Esophageal polyps are rare. The clinical presentation, diagnostic evaluation, pathophysiology, and treatment are discussed.*Wis Med J.1995;94(8)*:443-445.

Case report

A 59-year-old male had a 2-year history of dysphagia. Occasionally, while eating and sometimes after being aroused from sleep, he would have a sensation that food was caught in his upper esophagus. The patient denied a history of cough, choking, shortness of breath or recurrent pneumonias. Infrequently, he had symptoms of gastroesophageal reflux. No appetite disturbance was reported, nor had the patient lost weight. One or two alcoholic beverages were consumed a week.

No prior history of chemical ingestion or chest radiation was indicated. The patient had stopped smoking cigarettes 21 years earlier, after one package a day for 22 years. No family history of gastrointestinal malignancy was reported. Type II diabetes mellitus was controlled by diet and exercise.

An upper gastrointestinal barium X-ray series revealed a five-centimeter distal esophageal mass. Esophagogastroduodenoscopy confirmed, at 35 centimeters from the incisors, a pedunculated distal esophageal polyp on a four-millimeter stalk. There was a small sliding hiatal hernia and mild distal gastric antritis and duodenitis. A test for *Helicobacter pylori* was positive. Four biopsies of the polyp revealed adenocarcinoma.

A CT scan of the chest revealed a two and one-half centimeter ball-valving tumor (Figure). An abdominal CT scan revealed no evidence of metastatic disease. A transhiatal esophagectomy removed the tumor en masse.

Final pathological evaluation revealed an invasive, mucin- producing, moderately differentiated adenocarcinoma of the esophagus extending through the inner circular muscular layer of the esophagus. Random sections of the gastroesophageal region a few centimeters from the tumor confirmed a foci of Barrett's esophagus. Following recovery from surgery, the patient underwent three courses of Cis-platinum and 5-fluorouracil. Six months postsurgery, the patient showed no evidence of disease.

Discussion

A polyp at the gastroesophageal junction is a rare finding. The endoscopic and histological findings suggest that the cause is often gastroesophageal reflux. The reflux may occur in the absence of symptoms, or in the absence of hiatal hernia.[1]

The majority of polyps are located at, or immediately below, the squamocolumnar junction. The polyp may develop as a manifestation of peptic disease and reflux. There may or may not be evidence of esophagitis. Other causes of filling defects at the gastroesophageal junction include: varices, adenomatous polyps, foreign bodies, leiomyomas, and carcinoma.[2]

A proposed mechanism for the development of an esophageal polyp involves gastroesophageal reflux and the prolapse of the proximal gastric mucosa into the esophagus. This line of prolapse has been termed a sentinel fold.[3,4] The retrograde prolapse of gastric mucosa into the esophagus was described in the 1950s, but was first discussed in 1903. The mechanism of movement

Dr Cavanaugh is a thoracic surgeon and Dr Crandall is an oncologist, both at the Marshfield Clinic in Chippewa Falls. Dr Harrison and Dr Layer are internists at the clinic, and Dr Waits is a general surgeon there. Reprint requests to: Daniel G. Cavanaugh, MD, FACS, STS, Marshfield Clinic, Chippewa Falls Center, 2655 County Road I, Chippewa Falls, WI 54729. Copyright 1995 by the State Medical Society of Wisconsin.

of the gastric mucosa involves relaxation of the esophagogastric junction, excessive redundancy of the gastric mucosa, retrograde peristalsis of the stomach, and repeated regurgitation or vomiting.[5-7]

The history of this entity is confusing as there has been a variety of names given to the polypoid lesion, ie, inflammatory pseudotumor, fibrous polyp, and fibrovascular polyp. Confusion is even more pronounced when other entities are lumped into the diagnostic possibilities of distal esophageal polyp, such as pseudosarcomas and carcinosarcomas.[8]

Gastroesophageal polyps are rare in children but have been reported.[9,10] Adolescent patients with epigastric pain from situational stress have been shown to be candidates for the gastroesophageal polyp syndrome.[11] Gastroesophageal polyps have been treated with antireflux surgery in children and the polyp has resolved.[12]

Benign tumors of the esophagus are rare, and vigorous attempts at diagnosis must be undertaken to ensure that the patient is offered the correct therapy.[13] It has been stated in the past that esophagogastric polyps have such a characteristic appearance on esophagography that endoscopy and biopsy are unnecessary, but this has been shown to be false.[14] It is imperative to rule out the presence of carcinoma—endoscopy must be performed.[15]

The combination of radiological studies and endoscopy will aid in the diagnosis of gastroesophageal reflux and aid in the assessment of the rest of the upper gastrointestinal tract.[7] Provocative reflux tests may also play a role in the diagnostic tests of the distal gastroesophageal junction.

Radiographic studies should include a double-contrast barium study (using ingested barium and effervescent granules)[1], a single-contrast barium study, fluoroscopic studies, and a mucosal relief study.[16]

Recommended treatment of a distal esophageal polyp depends upon whether the lesion is benign or malignant. Benign polyps have been removed endoscopically,[17] or via a thoracotomy.[15] Antireflux surgery has resulted in the disappearance of benign polyps.[17] Vigorous medical therapy has also resulted in resolution of the lesion.[15] As in the case presented here, the diagnosis of a malignant polyp requires esophageal cancer resectional surgery. The value of adjuvant chemotherapy remains controversial.

Fig. - CT scan of the chest revealed a two and one-half centimeter ball-valving tumor.

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Ketorolac-induced postoperative acute renal failure: a case report

Nirav Y. Patel, MD, and Jeffrey Landercasper, MD, FACS, La Crosse

The nephrotoxic effects of nonsteroidal anti-inflammatory drugs (NSAIDs) are well recognized. Known potentiating risk factors include pre-existing renal disease, intravascular volume depletion, and concomitant administration of other nephrotoxic drugs. We present a case report of renal failure following short term usage of intramuscular ketorolac (Toradol) in a patient with no known risk factors who underwent an uncomplicated laparotomy. The literature concerning ketorolac-induced renal failure is reviewed and physicians are reminded to be aware of this potential complication.*Wis Med J.1995;94(8)*:445-447.

Renal dysfunction is a well recognized adverse reaction of nonsteroidal anti-inflammatory drugs (NSAIDs). Since its introduction in the United States in 1990, ketorolac, a parenteral NSAID, has been widely used in the management of postoperative pain. We describe a case report of acute postoperative renal failure attributed to intramuscular (IM) ketorolac administration in an otherwise healthy individual.

Dr Patel is a resident in surgery and Dr Landercasper is chair of the Department of Surgery, Gundersen Clinic, La Crosse, WI. Reprint requests to: Jeffrey Landercasper, MD, Department of Surgery, Gundersen Clinic, Ltd, 1836 South Ave, La Crosse, WI 54601. Copyright 1995 by the State Medical Society of Wisconsin.

Case report

A 54-year-old 100-kg man with a 2-year history of gastroesophageal reflux unresponsive to medical therapy was admitted to the hospital for elective Nissen fundoplication. His medical history included asthma, obesity, sleep apnea, and cholecystectomy. Admission medications included omeprazole 25 mg per day and imipramine hydrochloride 125 mg orally at bedtime. The physical examination was unremarkable except for obesity and a small, reducible umbilical hernia. Serum creatinine 16 months prior to admission was 1.3 mg/dL (normal range 0.6 to 1.5 mg/dL).

The patient underwent Nissen fundoplication with lysis of adhesions and umbilical hernia repair. He had received one gram of intravenous vancomycin preoperatively. The intraoperative course was unremarkable except for a single transient episode of hypotension, with systolic blood pressure of 60-70 mm Hg lasting less than three minutes. The patient received no blood transfusions. Intraoperative urine output was 550 mL.

After surgery the patient was transferred to the intensive care unit (ICU) and mechanically ventilated because of his history of sleep apnea. He was extubated the following morning and remained hemodynamically stable throughout his postoperative course. No postoperative hypotension occurred.

The patient received two doses of IM ketorolac. Sixty mg were given intraoperatively, one hour prior to transfer to the ICU, and 30 mg were administered 13 hours later. Eight hours after receiving the first dose of ketorolac, he became oliguric (urine output less than 30 mL per hour) for approximately 12 hours, with no significant response to intravenous fluids or furosemide. A gradual increase in urine output was noted thereafter.

The serum creatinine 15 hours after receiving the first dose and two hours after the second dose of IM

ketorolac was 2.9 mg/dL. Serum sodium was 138 mEq/L, urine sodium 31 mEq/L, and urine creatinine 72 mEq/L (renal failure index 1.25, fractional excretion of sodium (FeNa) 2.1%). The serum creatinine increased daily and peaked on the third postoperative day at 5.3 mg/dL. At discharge on the 12th postoperative day the serum creatinine was 2.0 mg/dL. Three weeks postsurgery, serum creatinine was 1.8 mg/dL.

Discussion

Ketorolac tromethamine (Toradol) is a nonsteroidal anti-inflammatory agent with analgesic, antipyretic and anti-inflammatory activities. The proposed mechanism of action is via reduction of prostaglandin synthesis by inhibition of the cyclooxygenase enzyme.[1] There is no known effect on opiate receptors. Elimination is primarily renal. Elderly patients may have loss of nephrons from aging resulting in reduced renal clearance of medication including NSAIDs. Allowance for this should be made in the dosage regimen employed. Ketorolac is available in IM and oral forms. The manufacturers recommend use of the IM form for no more than 5 days secondary to increased frequency and severity of adverse reactions.[1] These reactions may include, but are not limited to, gastrointestinal bleeding, operative site bleeding, renal failure, and allergic reactions.

A number of risk factors have been implicated that predispose to the renal dysfunction that follows the use of ketorolac and other NSAIDS. These include pre-existing renal disease, volume depletion, congestive heart failure, and cirrhosis with or without ascites.[1-3]

In well-hydrated patients with normal renal function, prostaglandins seem to exert little effect on the regulation of renal blood flow.[4,5] In contrast, patients with reduced renal blood flow for a variety of reasons may be more dependent on the vasodilatation of prostaglandins in maintaining normal renal homeostasis, electrolyte excretion, and urine output.[5] Prostaglandins are necessary for maintaining renal perfusion in patients with hypovolemia, arteriosclerosis, congestive heart failure, cirrhosis, renal insufficiency, and during concurrent diuretic therapy.[5]

Few studies have addressed the effect of NSAIDs on renal function during the perioperative period. Aitken et al, in a study of patients undergoing upper abdominal surgery, compared placebo to ketorolac 10 mg IM administered immediately after surgery and then continued at 4-hour intervals or by continuous IM infusion.[4,5] Their results indicated measurable changes in renal function during the postoperative period, but there were no significant differences between the study groups. Creatinine clearance was depressed below baseline during the 24 hours after surgery in both the ketorolac and placebo groups.

Schoch et al in 1992 reported a 71-year-old woman with pelvic and thoracic compression fractures who developed acute renal failure during the 48 hours following administration of three doses of 30 mg ketorolac IM.[2] With discontinuation of the NSAID, the patient was noted to have progressive resolution of renal dysfunction. She had a number of underlying risk factors, however, that made her susceptible to NSAID-induced renal failure. These included pre-existing renal insufficiency, hypovolemia and cirrhosis with ascites.

In contrast, our case demonstrates the potential of IM ketorolac to cause acute oliguric renal failure in a younger patient with no underlying risk factors. Ketorolac was chosen for analgesia because of the patient's history of sleep apnea and the desire to avoid a narcotic analgesic in this setting. Factors contributing to renal failure besides ketorolac may have included his transient mild intraoperative hypotension and the single preoperative dose of vancomycin. The patient was not given any other pre- or intraoperative nephrotoxic agent.

Personal communication with the manufacturer of ketorolac, Syntex Laboratories (June 1992), after a search of its database, revealed 70 patients with renal dysfunction and/or renal failure.[6] Syntex was aware of three case reports of renal dysfunction associated with use of ketorolac in the published medical literature as of June 1992.

In October 1993, Syntex Laboratories and Roche Laboratories presented an interim analysis of data from a large ongoing surveillance study of ketorolac at the University of Pennsylvania.[1] The interim analysis included 6,721 ketorolac courses. The interim results suggested that patient age, dosage, and duration of therapy increased the frequency of adverse reactions. Although no causality had been established in this preliminary report, the frequency of acute renal failure after ketorolac administration was 0.4% and 1.7% in patients less and greater than 65 years of age, respectively, when it was administered in a dose of 90 to 120 mg/day. The related acute renal failure rates after parenteral opioids were 0.2% and 1.0% for the respective age groups.

Ketorolac offers an alternative to the use of opiates in the management of postoperative pain. Physicians should be aware of potential adverse renal effects, however, including the potential for causing acute renal failure. In selected patients, risk factors may be present which increase the susceptibility of developing renal dysfunction with the use of ketorolac. Options of narcotic analgesics or reduced dosage of NSAIDs should then be considered.

Acknowledgments

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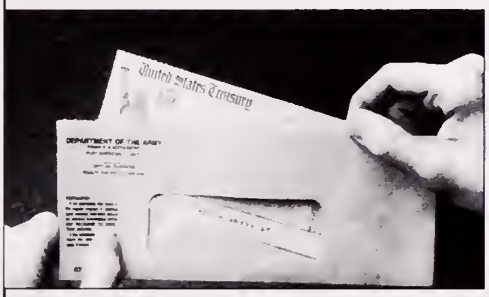

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Public health

Cardiovascular disease prevention projects in local public health agencies, Wisconsin, 1995

Linda Watson, MA; Susan Wood; Thomas Conway; and Patrick L. Remington, MD, MPH, Madison

In 1990, the U.S. Department of Health and Human Services released Healthy People 2000--National Health Promotion and Disease Prevention Objectives for the United States for the Year 2000.[1] These objectives established three broad goals for improving the health status of the general public: 1) to increase the span of healthy life for Americans, 2) to reduce health disparities among Americans, and 3) to achieve access for preventive services to all Americans. Wisconsin is one of 41 states that has developed a state specific plan to achieve these goals; mid-decade progress on the plan was reported in last month's *Wisconsin Medical Journal*,"Mid-Course Review: A Progress Report on the Healthier People in Wisconsin Year 2000 Agenda."[2]

Watson is a graduate of the University of Wisconsin-Madison Programs in Health Management. Wood is the section chief for Chronic Disease and Health Promotion. Conway is the supervisor of the Chronic Disease Prevention Unit. Dr Remington is the chief medical officer for Chronic Disease Control, Bureau of Public Health. Address reprint requests to Patrick Remington, MD, MPH, Wisconsin Division of Health, 1414 E. Washington Avenue, Room 251, Madison, WI, 53703-3041. Copyright 1995 by the State Medical Society of Wisconsin.

Cardiovascular diseases kill almost 1 million Americans each year and an estimated 2.5 million Americans are diagnosed with heart disease or stroke each year. In Wisconsin, heart disease is the leading cause of death, accounting for 14,028 deaths in 1992, and stroke is the third leading cause, accounting for 3,314 deaths in 1992; together these killer diseases make up 41% of all deaths in Wisconsin,[3] and 10 times as many suffer from these diseases (Division of Health, unpublished data). One of the goals set forth for the state is to reduce the heart disease mortality rate by 40% to 110/100,000 by the year 2000.

Since 1980, the mortality rate from heart disease has declined an average of 3.5% each year, reflecting the scientific advances that have linked the risk factors of high blood pressure, tobacco use, high cholesterol levels, and sedentary lifestyle to the disease, and reflecting the successful translation of these scientific advances into practice, as the public health and medical care systems have designed effective interventions to tackle these risk factors. Based on this rate of decline, it is likely the goal set for the year 2000 will be met, assuming continued progress in addressing the risk factors.

One important initiative to address this problem in Wisconsin is local health department cardiovascular disease risk reduction programs. These programs, provided by many local public health departments and tribal health agencies, are intended to reduce the health, economic and social costs associated with cardiovascular disease by targeting the risk factors of tobacco use, improper nutrition, sedentary lifestyle and hypertension. Funding for this program is a federal block grant to the states--the Preventive Health and Health Services Block Grant--that supports activities in pursuit of the Healthy People 2000 goals. The current year's allocation for all local programs supported by this funding source is $864,253.

In order to monitor the progress of this cardiovascular disease prevention program, the state of Wisconsin, Bureau of Public Health, Chronic Disease Prevention and Health Promotion section has compiled a directory of local health department CVD prevention programs. The listing contains all Wisconsin local health agencies that received Prevention Block Grant funds in fiscal year 1995 for cardiovascular disease reduction programs. In order to summarize plans the authors reviewed the contracts and work plans for each agency as well as the action steps formulated to meet the program's goals.

Overall, there are 61 local health agencies and Native American tribes providing CVD risk reduction programs to their respective communities. In comparing the programs statewide, there are a wide range of programs and services offered to the citizens of these communities. Many of the agencies offer individualized screenings for blood pressure and cholesterol, targeted primarily to local businesses. Most programs aim toward a strategy that is comprehensive in nature, providing health risk assessments and education about risk factors. Some agencies offer targeted services toward minorities, underinsured and uninsured populations, which is essential to achieving the year 2000 objectives as these groups bear a disproportionate burden from these diseases.

There is a growing effort in the areas of data collection, use of media advocacy, and collaboration with health care providers, in particular with managed care organizations who are actively engaged in health promotion activities. These strategies can aid programs in reaching larger segments of the overall population, thus increasing the impact of prevention efforts. This is consistent with the movement underway in the public health sector across the nation to focus the limited resources of the governmental public health agencies on the core functions of public health--assessment, policy development and assurance. These functions, as defined in the Institute of Medicine 1990 study *The Future of Public Health*, offer a framework for generating organized community effort to address the public's interest in health by applying scientific and technical knowledge to prevent disease and promote health.[4]

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Cardiovascular disease prevention projects in local public health departments, Wisconsin, 1995

The following is a list of health departments, contacts and program summaries:

Ashland County - Ruth Johnson - 715-682-7028
Screening in blood pressure and cholesterol is offered at five sites; follow-up consultation and referral is provided. Comprehensive education is also offered at each site.

Bad River Tribe - Mark LeCapitaine - 715-682-7137
Monthly screening for blood pressure, cholesterol, diabetes and obesity is provided at three sites with appropriate follow-up and consultation. Comprehensive education is also offered.

Bayfield County - Amelia Lindsey - 715-373-6109
A clinic-based system that incorporates prevention through comprehensive assessment and counseling that includes smoking cessation and follow-up on all smokers is offered. Special emphasis is on the needs of American Indians and low-income residents.

Brown County - Rebecca Meert - 414-448-6438
Program objectives are to provide screening and education to 1500 residents at worksite, with computerized follow-up of those with elevated readings. Health professionals are also trained in proper blood pressure measurement techniques. This project works closely with the Brown County Tobacco-Free Coalition.

Buffalo County - Narrate Willedsen - 608-685-4412
The main objective is to increase community access to comprehensive services, including educational consulting. There is a special emphasis on the farming population.

Burnett County - Dianne L. Gravesen - 715-349-2141
The primary objective is to increase the number of worksites offering comprehensive health promotion activities, including smoking cessation programs. A resource manual has been developed for worksite programs.

Calumet County - Rosemary Roy - 414-849-1427
Three worksite programs offer blood pressure, cholesterol screening, lifestyle assessment, education, counseling, referral and follow-up. Counseling and education are available at WIC clinics.

Clark County - Denise Vander Koy - 715-743-5105
Educational programs are provided to local businesses on nutrition, weight management, and cholesterol reduction.

Crawford County - Gloria Wall - 608-326-0229
One hundred twenty people at two factory worksites and one clinic site were surveyed to identify risk factors with counseling & follow-up offered. Blood pressure screening is also provided.

Cudahy, City of - Rosalie Hersil - 414-769-2239
Worksite screenings for blood pressure, lipid panels and computerized health risk profiles are offered to local businesses. These efforts are combined with appropriate education & referrals.

Dane County - Kate Sullivan Paul - 608-242-6520
In collaboration with Tobacco-Free Coalition, resource information is provided to assist establishment of tobacco-free environments at worksites. There is an increased emphasis on cessation programs throughout the community, i.e. through collaboration with schools, and with Women Infant and Children. Cardiovascular high reduction services are provided at worksites and community settings. These services include information, counseling and referral on exercise, diet, diabetes, smoking, blood pressure and cholesterol screening.

Door County - Jody Jessup - 414-746-2234
A Three-Phase Nutrition Education Program targets local restaurant owners and staff. The program is based on understanding, then implementing current U.S. Dietary Guidelines with computer analysis of existing recipes and tips for revision provided. The long range goal is a menu with a greater number of selections meeting or exceeding U.S. Dietary Guideline recommendations to better serve the health needs of patrons..

Douglas County - Patrick Heiser - 715-394-7221
Activities focus on screening for blood pressure and cholesterol at various locations. Comprehensive educational activities include nutrition and smoking cessation through fairs and media coverage. In addition, awareness programs are targeted to the middle school and unemployed.

Eau Claire County - Mary Ann Murphy - 715-839-4718
Activities include assessment of educational needs and service provision for diabetes and nutritional awareness. Blood glucose screenings are provided through the use of public and private partnerships: audience input is incorporated, and peer educators are recruited to target the southeast Asian population.

Fond Du Lac County - Marian Sheridan - 414-929-3085
Activities are directed to the reduction in tobacco use among Southeast Asian population through blood pressure screening and education that supports policies mandating clean indoor air.

Florence County - Karen Wertanen - 715-528-4837
Program aims to work with worksite and community groups to increase the proportion of sites who offer risk reduction activities. A blood pressure and cholesterol screening and awareness component is also provided.

Forest County - Judy Hitchcock - 715-478-3371
Program aims to develop comprehensive educational program with available resources emphasizing nutrition, fitness, blood pressure and cholesterol screening. Encouragement of policy development, e.g. media and education aids in establishing more tobacco-free environments.

Forest Co. Potawatomi Tribe - Janet Dailey - 715-478-3431
Comprehensive health assessments with follow-up for those screened for high blood pressure, cholesterol and glucose. Fitness facilities are also available for use.

Continued on next page

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Franklin, City of - Carol Sibilski - 414-425-9101
The program focuses on assessment through systematic collection and analysis of data from regular blood pressure screening. In addition, morbidity and mortality information is analyzed so that priorities for services can be developed.

Green County - Kathy Brockman - 608-328-9390
The program aims to increase activity levels among residents in seven communities, thus improving cardiovascular health. Walking groups are organized in work places, villages and schools, and offer special walking events each month.

Green Lake County - Kathryn Munsey - 414-294-4070
Comprehensive screening using a risk reduction screening form is provided. Detailed epidemiologic data will also be shared after individual follow-up and consultation.

Greenfield, City of - Carol Skierka - 414-543-5500
Program interventions focuses on tow areas: 1) nutrition, and 2) screening in blood pressure and cholesterol. Nutrition component addresses worksite education, staff development and distribution of resource materials.

Iron County - Deborah Swartz - 715-561-2191
Program focuses on worksite education and screening regarding tobacco, physical activity and nutrition. General education is provided through media and health fairs targeted to all Iron county residents.

Jackson County - Karen Byrns - 715-284-4301
Program emphasizes nutritional education to worksites. Topics include weight management, normal nutrition and cholesterol education.

Kenosha County - Julie Newhouse - 414-653-6434
Project interventions focuses on: 1) blood pressure and cholesterol screenings at area clinics, worksites, and special events with follow-up and referral; 2) education and counseling with community resource listings; and 3) assistance to Kenosha County Tobacco-Free Coalition.

Kewaunee County - Marilyn Melchoir - 414-338-4410
A comprehensive prevention education program to primarily address smoking. The program is targeted to industries, adolescents, pregnant women, and parenting families in WIC.

Lac Courte Oreilles Tribe - Carol Mott - 714-634-8934
A wide scope diabetic prevention intervention and education program utilizes case finding with assessment and follow-up. Emphasis is on nutritional health, with a diabetic support group.

LaCrosse County - Al Graewin - 608-785-9872
The program's emphasis is to increase community availability and accessibility of physical activity and fitness facilities. Ongoing screenings are held as well as a health and fitness fair.

Lac du Flambeau Tribe - Gen Safford - 715-588-3371
The program aims to promote the integration of nutrition, as well as fitness, and hypertension awareness into the existing community fitness program through outreach.

Langlade County - Norma Winter - 715-627-6250
Twenty work sites (app. 400 clients) receive the following services: health risk appraisals, screening for blood pressure, and cholesterol, as well as follow-up and counseling on comprehensive risk reduction including smoking cessation classes.

Manitowoc County - Jim Blaha - 414-683-4155
Funding will be used for staffing a tobacco control coordinator to assist existing coalition members with planning and outreach activities. Other interventions focus on improving the nutrition and physical activity status of the community by developing and implementing a communications plan to disseminate messages to specific target groups as well as the general public.

Marinette County - Mary Mursau - 715-732-7670
This program provides worksite-based screenings to 18-55 year olds, targeting the underinsured or uninsured worker. This cardiovascular health risk assessment includes blood pressure, blood glucose and cholesterol testing, education, counseling, and follow-up for approximately 400 persons.

Marquette County - Suzanne McCartney - 608-297-9116
The program conducts screenings in blood pressure and cholesterol for at least two worksites or volunteer groups, high schools and special events.

Menasha, City of - Jeanette Bryan - 414-751-5119
The project focuses on screenings for blood pressure, carbon monoxide, and cholesterol in selected worksites; opportunities are provided to assist in developing comprehensive wellness programs. Educational activities are offered to restaurants and the at-large community on nutritional and fitness programs.

Milwaukee, City of - Evelyn Merriett - 414-286-8830
A coordinated community effort including a consortia (Oak Creek, St. Francis & South Milwaukee) offers interventions targeted to African American, and other minorities, such as low-income, and under and uninsured. Major components of the program include screening for blood pressure, referral, consultation, public awareness, volunteer and professional training, group and individual education.

Monroe County - Sharon Nelson - 608-269-8666
Five worksites provide comprehensive assessments and education to include cholesterol control and blood pressure screenings; worksites are encouraged to promote heart healthy foods in vending machines. In addition, a community-wide media plan has been developed and implemented to increase nutritional awareness.

Oneida County - Marge Saari - 715-369-6104
Assistance is provided to establish worksite-based comprehensive programs including blood pressure and cho-

lesterol screening for underinsured and uninsured, and inservice training. Smoking cessation, health and nutrition, and cancer and heart disease classes are offered, and a quarterly newsletter is mailed to all participants.

Ozaukee County - Carolina Voss - 414-284-9411
Program provides services to clients age 18 and over, the minority population and those with a family history of cardiovascular disease. Services include comprehensive health risk screenings, counseling and follow-up to six worksites at three public health screenings, five monthly blood pressure sites and one low-income site.

Pepin County - Sharon Prissel - 715-672-5961
Comprehensive risk reduction activities for school, community and work sites include screenings for blood pressure, cholesterol, and glucose; referral to health care provider as needed; follow-up and education.

Pierce County - Raymond Cink - 715-273-3531
Activities focus on providing comprehensive nutritional services including screening , counseling and medical referral for cholesterol, triglycerides and blood pressure. These services are offered at four office sites, as well as schools and businesses in the county. Target populations include the uninsured and the underinsured.

Polk County - Karen Dalzell - 715-485-3938
Program emphasizes worksite risk reduction, to include risk assessments, with blood pressure and cholesterol screening. Comprehensive education includes smoking cessation classes.

Portage County - Paula Smith - 715-345-5350
The program focuses on the formation of a coalition to develop population-based strategies that fit the community's needs and the coalition's capacity. These efforts include topics of diet, nutrition, and tobacco use, working in coordination with Tobacco-free Coalition.

Racine, City of - Pat Holly - 414-636-9292
The core of the program is cardiovascular screening in the work place involving blood pressure, cholesterol, blood sugar and lifestyle study and counseling. A new venture into the community, church and civic area highlights heart health education.

Red Cliff Chippewa Tribe - Joan Slack - 715-779-5801
The goal of this multi-disciplinary intervention is to provide formal education in order to improve the care of the patient diagnosed or at-risk of developing diabetes.

Rock County - Mat Haeger - 608-757-5442
Three worksites offer health risk assessments to include blood pressure and cholesterol screening along with appropriate follow-up and referral.

Rusk County - Kathy Mai - 715-532-2177
Health assessments, screening, counseling and follow-up are conducted in the areas of cholesterol and hypertension control. Media involvement is also used to inform the community about additional risk factors.

Sokaogon Chippewa Tribe - Lynn Barker - 715-478-5180
Program aims to develop a community fitness program with exercise classes, health summaries and community education.

St. Croix Chippewa Tribe & Ho-Chunk Tribe
Ardys Noreen- 715-836-5363
Program focus is to assist the cigarette smoker toward overcoming nicotine addiction with an extensive program of behavior modification . This is achieved through counseling, group sessions, and patch therapy. Fitness programs are also promoted.

Sawyer County - Corinne Olson - 715-634-4874
Comprehensive health risk appraisals are offered at worksites and public health sites to include blood pressure, blood glucose, and cholesterol testing. Those at risk receive education, referral and follow-up. Other professional and media involvement are utilized to promote these services.

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Shawano County - Janet Lewellyn - 715-526-4808
Program services incorporate a comprehensive strategy that includes self-awareness promotion and education to target minorities and low-income groups. Interventions shift toward policy-based, media usage and service availability. Broad-based community collaboration are emphasized within the program's goals.

Sheboygan County - Sharon Daun - 414-459-6438
Funding for this project supports two large collaborative prevention efforts: "Healthy Sheboygan County 2000" and Tobacco-Free Coalition. HSC 2000 represents public and private health organizations, strategies are comprehensive, and agency staff develop educational materials. The coalition's overall goals are to establish tobacco-free programs at worksites and in schools.

Shorewood, Village of - Cynthia Tomasello - 414-963-6986
Comprehensive screening and counseling is offered through the use of a valid health risk appraisal tool.

St. Croix County - Barbara Nelson - 715-349-2195
The program aims to promote comprehensive worksite-based strategies that provide prevention education while the agency continues to act as a resource for "Shape Up" aimed toward increasing activity levels. A newer program, "Stepwell" is also being expanded from schools to include greater community involvement.

Vernon County - Elizabeth Johnson - 608-637-2233
Comprehensive health risk appraisal is offered at various worksites, with emphasis on high-risk groups such as low-income, and the under- and uninsured. Collaboration with other agencies is being formed to provide referrals, and additional information, such as nutritional counseling.

Vilas County - Dolores Ludwig - 715-479-3656
Broad-based community activities include the following: health risk appraisals, screening and referrals for blood pressure and cholesterol, surveys and education regarding tobacco-free environments, e.g. heart healthy menus, and promotion of physical activity.

Walworth County - Pat Grove - 414-741-3140
Comprehensive strategies are used to increase awareness of area resources and promote education through community-wide efforts within three core functions: media efforts, policy promotion and program services interventions.

Washington County - Delores Harder - 414-335-4462
Program aims to provide blood pressure and cholesterol screenings, and follow-up at work and community sites through mass media educational efforts including smoking cessation classes. In addition, a fitness program is being promoted.

Waukesha County - Rosie Schroeder - 414-549-3012
Cardiovascular risk reduction efforts are coordinated with the Healthy Waukesha Plan 2000 and the Waukesha County Tobacco-Free Coalition. The program has two major focus areas: Blood Pressure Screening Program and Worksite Wellness Program. The Blood Pressure Screening Program includes screening at 24 community sites and quality assurance. The Worksite Program conducts and utilizes a survey on worksite wellness programs to provide consultation, education, and resources to promote cardiovascular wellness; will also promote healthful environmental changes in the work place.

Waupaca County - Barbara Black - 715-258-6385
Program emphasizes a comprehensive worksite program with a biannual newsletter, paycheck stuffers, and an annual screening with follow-up and referral for blood pressure and cholesterol.

Waushara County - Pam Schmelzle - 715-787-4661
Ten worksites offer comprehensive health risk appraisals with counseling and follow-up. In addition, the health department provides blood sugar screening and education as a means of case finding new or undiagnosed diabetics.

West Allis, City of - Melissa Hanson - 414-256-8387
The program targets 18-55 year-olds, minorities, and under- and uninsured groups with health assessments, including glucose, blood pressure and cholesterol screenings. The prevention team has shifted its emphasis to worksite interventions, including presentations and resource material development.❖

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The disruptive-abusive physician: A new look at an old problem

David G. Benzer, DO, and Michael M. Miller, MD, Statewide Physicians Health Program

PHYSICIANS BECOME ILL from time to time; it is part of the human experience. When a physician's ability to practice medicine safely and efficaciously is compromised by illness, it is termed impairment.[1]

For years the term physician impairment has been synonymous with chemical dependency. At the dawn of the physicians' health movement in the 1960s and 1970s, chemical dependency was by far the most common etiology of physician impairment; it remains so today.[2] Other etiologies of impairment, however, are being increasingly recognized including: mental illnesses, physical illnesses and stress.[3] Cases of physician incompetence or malpractice are not considered to fall within the realm of physician impairment unless a performance deficit is deemed to be related to a personal illness on the part of the physician.

Organized medicine, including the SMS, has taken a leadership role over the past two decades in dealing with cases of physician impairment.[3] Since 1977, the SMS Statewide Physicians Health Program (SPHP)-formerly titled the Statewide Impaired Physicians Program (SIPP)-has provided Wisconsin physicians with information about physician health issues.[3-5] The SPHP also reaches out to physicians who may be ill and provides assistance in procuring evaluation, treatment and monitoring of these physicians. The SPHP receives self-referrals to the program as well as referrals from colleagues, hospitals, clinics, patients and other concerned citizens.

While substance abuse and dependence remain the most common etiology of physician impairment reported to SMS SPHP, the shift in recent years towards nonaddictive conditions as etiologies of physician impairment has been mirrored in the data from Wisconsin. In 1991, the first case of impairment due to stress was reported to SMS SPHP. Since then, there have been two to three reports each year.

More recently, referrals to SPHP relate to cases of physician impairment manifested by disruptive-abusive behavior by the physician. After the first such referral in 1985, there were two cases of disruptive-abusive physicians reported in 1991, one in 1992, two in 1993 and eight in 1994. The 1994 referrals represented almost 30% of the total referrals to the SMS SPHP for that year.

This paper focuses on the problematic behaviors that can be referred to as disruptive or abusive behavior by physicians, and the adaptive and maladaptive responses of others in the health care environment that may occur in the face of this behavior.

Historical perspective

A medical literature review on disruptive-abusive physicians would lead us to believe that this problem first appeared in the 1990s. Papers discussing disruptive-abusive physicians began to appear in the 1990s, primarily in publications within the nursing profession.[6-8] Of course, common sense and the experience of hospital administrators, medical staffs and nursing staffs tells us that this issue has been a feature of the health care scene for generations.

Almost any physician can recall instances from his or her training or past practice experiences in which there was a verbally abusive or intimidating physician at the nurses' station or in the surgical suites, berating staff verbally, throwing surgical instruments, demeaning anesthesiology personnel, or even striking other members of the health care team. Yelling at patients also occurs and while such behaviors have resulted in whispered comments, gossip or quivering silence, inappropriate verbal or physical aggression with patients or staff was largely tolerated over the years.

Disruptive-abusive behavior by physicians that may have been tolerated a decade or two ago, however, may not be tolerated today. This shift in the way that others feel about or take action in response to unacceptable physician behavior, may well be a parallel of what has occurred in society as a whole. Verbal abuse and sexual harassment in the workplace have been increasingly scorned; there are new standards by which behavior in the workplace is being judged.

Physicians are also subject to these new workplace standards. When they do manifest disruptive-abusive behaviors, the intolerance of the observer or the recipient of abuse may generate a reporting of the physician to a local or state physician health program or even to the Medical Examining Board.

Thus, instances of disruptive-abusive behavior by physicians have occurred in the past, but only recently are being viewed as unacceptable or aberrant behavior. The cases of inappropriate physician behavior may be manifestations of individual-

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als continuing to conduct themselves in a manner previously tolerated. The offending individual, however, is out of touch with current expectations and standards, and is not aware that such behavior no longer conforms to contemporary standards of decorum.

The appearance of cases of disruptive-abusive physicians has presented new challenges and responsibilities for physician health programs. Just as there are issues of case recognition, case intervention, treatment and reentry into medical practice for other impaired physicians, these issues must be addressed for the disruptive-abusive physician.

Impact on patient care

There are several possible ways disruptive-abusive behavior can impair or compromise patient care. The most direct adverse effect is due to decreased efficiency on the part of the physician. Inappropriate venting of emotions or other behaviors associated with this condition, deflect the attention of the physician from patient care, resulting in errors in clinical judgment and performance. Further, if the abusive behavior of the physician involves sexual harassment, the anxiety in the offending physician at the prospect of being detected in one's inappropriate sexual behavior in the workplace can distract the physician in the midst of his or her patient care functions.

Secondly, the disruptive physician can impair the effectiveness of the entire health care team. For example, nurses, allied health care professionals and physician colleagues may be so anxious or intimated in the face of a physician's disruptive-abusive behavior that they may lose their usual clinical focus and productivity. Other times, these colleagues may veer from their usual course of professional activity, going out of their way to avoid the disruptive-abusive physician.

Impaired communication within the health care team, as a result of the disruptive-abusive physician, may further compromise patient care.

Pathogenesis

Disruptive-abusive behavior is not an illness in and of itself; it is often a symptom manifesting underlying pathology. The differential diagnosis of the disruptive-abusive physician includes addiction, stress and psychiatric disorders.

Substance abuse or stress. In the SPHP's experience, addiction rarely presents as disruptive-abusive behavior. Even though aggressiveness, intrusiveness or hyperactivity are well known effects of stimulant drug intoxication (such as cocaine and amphetamines), and, irritability and argumentiveness may be manifestations of alcohol or sedative withdrawal, it is usually problems other than verbal or physical abuse in the workplace that bring to light a physician with a substance use disorder.

Still, when disruptive-abusive behavior is witnessed on the part of a physician, the differential diagnosis should include the possibility of substance abuse or dependency.

Stress impairment is a cause of physician impairment that is increasingly being reported to the SMS SPHP.[3] Progenitors of stress impairment--which include increased work hours and decreased leisure time--can lead to or perpetuate the disruptive-abusive behavior.

Major psychiatric illnesses or disorders. Psychiatric conditions may influence a physician's well-being. Since major psychotic disorders typically onset at ages prior to medical school graduation, it is unlikely that a practicing physician would have a major psychiatric illness. Major illnesses, such as schizophrenia, will likely develop early enough and disable the individual sufficiently so that he or she is unable to progress through medical education, postgraduate training, and enter practice.

Major affective disorders do affect physicians, however, and major depressive episodes can involve irritability and anxiety, leading to intense verbal reactions or explosions.

More commonly, manic or hypomanic episodes can involve sleep disturbance, rapid thinking, rapid shifts in affect, or intrusiveness that can adversely affect interpersonal communications and physician decorum in the workplace. Further, grandiose thinking or a sense of specialness on the part of the manic physician can lead to imperious or domineering behavior patterns. As with addictive disorders, there are usually manifestations of psychiatric disturbances other than disruptive-abusive behavior.

Personality disorders. The final area of pathology that can underly disruptive-abusive behavior is the realm of personality disorders.

Narcissism is a personality disorder that may test the patience of a person in the midst of the afflicted individual. Persons with narcissistic personality disorder have been described as having: "A grandiose sense of self-importance. They routinely overestimate their abilities and inflate their accomplishment, often appearing boastful and pretentious. They may blithely assume that others attribute the same value to their efforts and may be surprised when the praise they expect and feel they deserve is not forthcoming. Often implicit in the inflated judgments of their own accomplishments is an underestimation (devaluation) of the contribution of others. They are often preoccupied with fantasies of unlimited success, power, brilliance, beauty or ideal love. They may ruminate about "long overdue" admiration and privilege and compare themselves favorably with famous or privileged people."[9]

Physicians with this disorder often have their condition reinforced by the special and unique prerogatives granted to physicians as a re-

sult of their profession. Physicians are often recipients of grateful flattering or praising feedback from others which a non-humble narcissist can use to feed their inflated sense of self-importance. The narcissistic physician may feel particularly entitled to conducting himself or herself in a manner that can include disruptive or abusive behaviors.

Learned behavior. Finally, the disruptive-abusive physician may develop behavior problems not because of a diagnosable mental disorder. Instead their behavior may simply have been learned, reinforced, developed, tolerated and enabled. Thus, a disruptive-abusive physician may have developed a maladaptive behavior pattern based on modeling, experience and reinforcement and this may be behavior that can be unlearned rather than an illness to be treated. Whether the etiology of the disruptive-abusive behavior is an underlying illness or simply old behavior, the physician exhibits behavior problems that affect the health care delivery system and may result in a call for help from a hospital or clinic to an organization such as the SMS SPHP.

Presentation

Recognizing disruptive-abusive behavior is usually not difficult. In fact, within a given institution, it is often difficult to find someone who is not aware of individuals who manifest this problem. The following are possible presenting symptoms of the disruptive-abusive physician: physically assaultive or intimidating; verbally abusive or threatening; publicly berating or demeaning displays; throwing objects (such as surgical instruments); yelling or condescending speech; excessively argumentative or insulting; and sexually intrusive, harassing or abusive speech or behavior. Two other characteristics of this syndrome include: long-standing duration of the problem, i.e., years, and extreme frustration of peers, staff and administration of clinics and hospitals. The behavior of the disruptive-abusive physician is usually long term. By the time, the physician is finally reported outside of the institution, there usually have been multiple unsuccessful attempts to intervene and modify the behavior.

Responses of the affected parties. Colleagues or others affected by disruptive-abusive physician behavior are placed in a very awkward position. First, they may feel demeaned, and this may lead them to question their own confidence or integrity as they wonder "could that outburst have been warranted by my deficiencies?" They may feel angry-and justifiably so. They may feel indignant. If they are subordinate, they

Continued on next page

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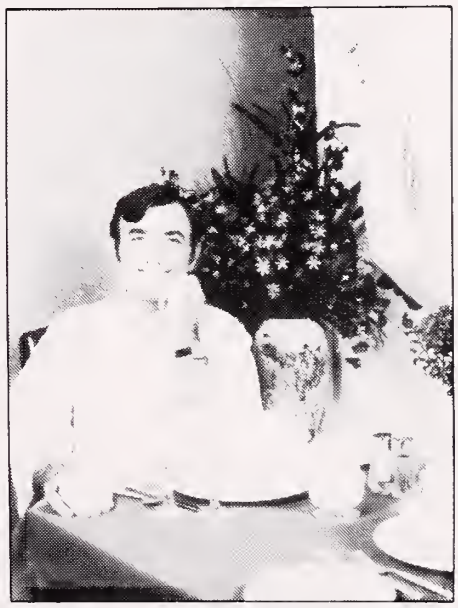

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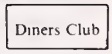

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may feel powerless at first regarding what sorts of responses are possible.

The dilemma faced by such individuals bear similarities to the dilemmas faced by co-dependents.[10-12] Like the co-dependent, the initial response is to deny that there is a problem, to act as if it isn't happening. Next, the behavior is tolerated; affected individuals swallow hard, they "grin and bear it," and hope and pray that the behaviors will "just go away" or that the disruptive-abusive physicians will change their behaviors spontaneously without any intervention.

Over time, affected individuals cannot deny they are being distressed and their ability and willingness to tolerate the intolerable is exceeded. At that point, realizing that there is an issue to be addressed, they experience anxiety, worry and fear: What do I do? And if I do it, what will be the consequences?

This sense of powerlessness in its early form is often accompanied by feelings of helplessness and anger. Only later, having taken appropriate steps to maintain their personal integrity, to affirm their value and worth, can co-dependent persons develop a sense of comfort, acceptance and a healthy acknowledgment of existential powerlessness.[3]

The identical sequence often occurs when one interfaces with the disruptive-abusive physician; anxiety, frustration, helplessness, and anger are often emotional responses of subordinates, coworkers and even superiors of disruptive-abusive physicians.

Other processes--parallel to dealing with chemically dependent physicians--confront those dealing with disruptive-abusive physicians. The disruptive-abusive physician may have prominence and stature within the medical community and within the larger community despite his or her pattern of disruptiveness or abusiveness. The physician may be so financially productive that he or she seems absolutely essential to the economic well-being of the hospital or the clinic. Or, especially in a rural area, he or she may be viewed vital to the town as a whole.

The potential removal from practice of a physician intervened upon because of mental disorder, chemical dependency or disruptive-abusive behavior can thus be a frightening prospect for some, as well as a prospect of some forthcoming relief.

Therefore, "the price to be paid" for confronting and intervening may be significant. There may be fear of job losses, especially a direct job loss by a subordinate who may be courageous enough to step forward. Also there may be resistance to speaking out and intervening in the case of a disruptive-abusive physician, just as with chemically dependent physicians. There may be a pattern of denial, tolerance and covering up on the part of administrators and this may be well known to all so that individuals lower in the organizational hierarchy have been shown by modeling that intervention is not the thing to do.

Responses of health care organizations

The initial issue to be considered by a hospital or clinic when addressing the issue of disruptive-abusive physicians is not, "What can the offending physician do differently," but "What those affected do differently?" This begs for not only an institutional response but an individual response on the part of every individual affected by the abuse.

The first step is to stop denying there is a problem. Individuals must be aware of the problematic behavior of the afflicted physician, then must be aware of their own feelings that have been generated by the situation. Next, each individual must be true to his or her own feelings and not deny them. One can seek to validate his or her observations, experiences and affective responses by sharing experiences with others. This is a process of benchmarking, not one of gossiping.

Once it is clear that there is a commonly repeated shared experience of a physician's decorum being disruptive or abusive, there can be a decision to intervene. Intervention may involve extramural referral.

Thus, individuals in health care organizations, hospitals and clinics, must first be validated, and then be empowered, before it is likely that there will be the subsequent action necessary to resolve an issue of a disruptive-abusive physician.

Intervention and referral

Once a presumed case of physician impairment due to disruptive- abusive behavior has been detected, the next step is intervention and referral. An organization such as a hospital or clinic can refer a case to its own physician health committee, if one exists. Other organizations may prefer to have these situations dealt with by physician administrators as well as hospital and clinic administrators. Some organizations prefer to refer cases for potential intervention to an extramural entity such as the SMS Statewide Physician Health Program (SPHP).

The basic principles of intervention that are useful in dealing with other types of physician impairment will serve well when confronting the disruptive-abusive physician.[14] Some of these principles of intervention by peers which may facilitate a successful outcome of the process are as follows:

- *Use of multiple intervenors.* Two or more peers involved in meeting with the physician who is presumed to be impaired.
- *Appropriate timing.* Intervention should be carried out as soon as possible after the occurrence of a crisis that is precipitated by that impairment.
- *Selection of intervenors.* Individuals with knowledge of specific consequences of the disruptive-abusive behavior should participate in the intervention. Individuals with knowledge of and

experience with the techniques of intervention should participate in the intervention and facilitate the process; and intervenors should be able to present themselves in a nonjudgmental, empathetic manner and should be able to present specific data or documentation about the problematic behavior in a rational, objective manner.

- *Preparation for the intervention.* Intervenors should prepare themselves by having at their disposal data from specific incidents of disruptive-abusive behavior which have occurred; they should decide about what will be presented by which participant and in what order; and they should decide what is to be expected of the physician who is being intervened upon.
- *Location of the intervention.* Intervenors should select a site that is private, quiet and nonthreatening (this may include the private office of one of the intervenors, or of the intervenee, but should not include doctors lounges, cafeterias or hospital corridors).
- *Anticipate possible reactions.* Intervenors should expect that the doctor will not be pleased to hear these concerns. Anger, defensiveness, sadness or shame can be better dealt with by the intervenors if this is anticipated.
- *Demonstrate genuine concern.* This is the optimal response to the defensiveness that may be evoked in the impaired doctor. It needs to be evident to the doctor that the intervenors are being motivated by care and concern. If there are ulterior motives, these will be quickly perceived by the doctor and the effectiveness of the intervention will be diminished.

Evaluation and treatment

The goal of intervention in any case of possible physician illness or impairment should be a professional evaluation of the physician. By recommending evaluation, the intervenors can avoid making a presumptive diagnosis themselves. Moreover, by defining the role of the professional evaluation as outside of the parameters of the intervention, the role of the intervenors can be circumscribed. These boundary demarcations are especially important in the case of the disruptive-abusive physician because of the multiple etiologies of this condition.

Referral for evaluation should be made to clinicians experienced in the care of impaired physicians. Such clinicians see enough cases to be able to perform the necessary differential diagnosis. Many clinicians are affiliated with institutions that specialize in physician health evaluation and treatment, and that use multidisciplinary staffs including the medical, psychiatric and psychologic services needed to take appropriate diagnostic and therapeutic steps.

Treatment of the disruptive-abusive physician depends upon the etiology of the condition. Addiction, if present, must be treated. Abstinence from alcohol and other drugs must be achieved and then maintained so that remission can take the place of active addiction. Recovery from addiction will often end disruptive-abusive behaviors that have been associated with addiction. In other cases, stress management strategies should be employed for the physician in whom physician stress syndrome has led to the disruptive-abusive behavior. Clinical steps may include the prescribing of a long leave of absence from the workplace in order for the physician to acquire and develop the improved coping skills and life balance necessary for the remission of stress impairment.

Finally, ongoing psychiatric care for any affective or personality disorders can help ameliorate these conditions when they have led to a pattern of disruptive-abusive behavior.

Monitoring and reentry to medical practice

Not all cases of disruptive-abusive physicians require reentry assistance; many are able to continue working while ongoing treatment is occurring. Reentry support for those who have not been working due to treatment should be available from local clinic and hospital physician health committees where available. SMS SPHP is always available to help with reentry issues whenever contacted. All physicians who have been evaluated or treated require validation from their evaluating or treating physician that they are safe to return to the practice of medicine. Furthermore, documentation of their ongoing treatment and fitness-for-duty should be requested by clinics and hospitals where previously disruptive-abusive physicians are returning to work. SMS

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SPHP suggests no less than quarterly reports from the recovering doctor's treating physician.

Relapse

Once the recovering disruptive-abusive physician has returned to practice, be it after a 1-day evaluation or a year long sabbatical, occasional reappearance of old behavior may occur. Such reoccurrence should be reported to the treating physician as soon as possible. It must also be brought to the attention of the recovering physician. Prompt mirroring of the unacceptable behavior is a key to modifying that behavior.

It is unreasonable to expect a "cure" for disruptive-abusive behavior. Rather, with ongoing treatment, it should become less severe and less frequent and finally be extinguished.

"Psuedo-relapse" refers to behavior on the part of the recovering physician that to an objective observer appears appropriate. However, when this behavior is observed by someone who has previously been subjected to the disruptive-abusive behavior, it may trigger an exaggerated response. Unrealistic expectations or lingering resentments on the part of previously affected staff may result in continued reporting of behavior problems on the part of the recovering physician. At times the only way to stop this circuitous process is to provide assistance to affected staff members who may need help in dealinq with their post-traumatic stress type symptoms.

Role of SMS SPHP

Since its inception in 1977, the SMS SPHP has served as a resource for helping physicians in Wisconsin. SPHP has served as a model of organized medicine's response to physician impairment. SPHP stands ready to assist colleagues, clinics or hospitals in identifying, intervening, evaluating and monitoring physicians with disruptive-abusive behavior or other forms of illness and impairment. By doing so, we not only serve to provide assistance to our peers but also protect the quality of medical care being received by the citizens in this state.

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A word from WIPRO
Initial management of community-acquired pneumonia

Jay A. Gold, MD, JD, MPH, Madison

In 1994, members of WIPRO's Steering Committee suggested that many hospitals might be interested in participating in a project to improve initial management for patients with community-acquired pneumonia. The Kansas PRO had done a project in this area, and WIPRO obtained documentation from them, deciding to adopt some of their approach and to change other aspects of it.

WIPRO contacted PRO contacts at all 126 Wisconsin acute care hospitals to let them know of the opportunity to collaborate in this area. A total of 48 hospitals expressed an interest in collaborating. We chose seven hospitals as formal collaborators, and offered the others a chance to participate by abstracting their

own data using our data collection form, after which WIPRO would analyze their data and return their results to them. Twenty-nine hospitals participated in this fashion.

A study group was formed, consisting of four physicians (including specialists in pulmonary and infectious disease), as well as staff representatives from collaborating hospitals. After a review of the literature, especially the guidelines of the American Thoracic Society[1] (ATS), clinical indicators were adopted (Table). While the American Thoracic Society guidelines came out in mid-1993, the study group felt that they remained useful as guides to improvement. The ATS guidelines state that Gram's stain and sputum cultures frequently give uncertain results, but that they sometimes are diagnostic; for hospitalized patients, they recommend two sets of blood cultures.

A form was constructed to collect relevant information from hospital charts. In total, 1,050 cases from collaborating hospitals were included, covering Medicare pneumonia admissions in calendar year 1993. Data were abstracted from the charts using the data collection instrument, and rates were calculated for individual hospitals, for the sample as a whole, and for peer groups of small, medium, and large hospitals as classified by the rate-setting commission.

Results of the analysis were extremely interesting. First of all there was a significant relationship between hospital size and the rapidity with which antibiotics were started: most small and medium-sized hospitals started antibiotics within 4 hours, while most larger hospitals were in the 4-6 hour range. Secondly, we found that for all hospital sizes, patients seen initially in the emergency department had a longer wait for antibiotics than those admitted directly: an average of 4.4 hours for the former versus 2.8 hours for the latter.

We found that Gram stains of sputum cultures were ordered in three fifths of the cases examined. Regarding sputum cultures, we found that: 1) they were ordered in three fourths of the cases; 2) that four fifths of the time an adequate specimen was obtained; and, 3) that with an adequate specimen an organism was identified in half of the cases.

Use of blood cultures was very different: 1) they were ordered 70% of the time, and 2) they led to identification of an organism in less than 6% of cases where blood was drawn.

Our communications strategy had two parts. WIPRO physicians visited each collaborating hospital to present both aggregate and hospital-specific data and to discuss the indicators. Most collaborating hospitals then submitted improvement plans, which they now are in the process of implementing or have implemented. The most frequent goal of improvement plans was to decrease the time between presentation and initial administration of antibiotics.

On Oct 28, 1994, WIPRO sponsored a videoconference featuring Dr Dennis G. Maki, chief of infectious disease at the University of Wisconsin and a member of our study group, who discussed the practice variations in the study and made recommendations for initial management of pneumonia patients, emphasizing choice of antibiotics. In addition, a panel of representatives from hospitals that had undertaken their own improvement projects shared what they had done.

ATS Clinical Guidelines

- Time from presentation to initiation of antibiotics
- Orders for sputum Gram stain
- Orders for sputum culture
- Orders for blood culture

WIPRO soon will be collecting follow-up data that will show whether the performance of collaborating hospitals has improved; such data may indicate whether further improvement efforts are desirable.

Reference

1. American Thoracic Society, Guidelines for the Initial Management of Adults with Community-Acquired Pneumonia: Diagnosis, Assessment of Severity, and Initial Antimicrobial Therapy, *American Review of Respiratory Disease*. 148(1993):1418-1426.❖

A word from WIPRO is not reviewed by the *WMJ* Editorial Board. Dr Gold is WIPRO's Principal Clinical Coordinator. He also serves as Assistant Clinical Professor of Preventive Medicine and Bioethics at the Medical College of Wisconsin, and as Senior Lecturer in Preventive Medicine at the University of Wisconsin, Madison. Reprint requests to Jay A. Gold, MD, JD, MPH, WIPRO, 2909 Landmark Place, Madison, WI 53713. Copyright 1995 by the State Medical Society of Wisconsin.

WIC Update: The physician's role in helping families, pregnant women obtain good nutrition

Carol Huber, executive director, Wisconsin Nutrition Project

FEDERAL NUTRITION programs are getting a lot of attention as Congress debates consolidating child nutrition programs in block grants to the states. Some of the issues this debate raises for physicians are reflected in the following questions:

- "What is WIC?"
- "How can physicians help their patients?"
- "How might all the proposed changes in nutrition programs affect patients?"
- "Should one continue to refer patients to the WIC program?"

This article will address these questions as well as provide physicians with follow-up resources.

What is WIC?

The special supplemental nutrition program for **W**omen, **I**nfants and **C**hildren (WIC), is a program in which pregnant women, postpartum and breastfeeding women as well as infants and children, up to age 5, may qualify for vouchers for specific nutrient-rich foods, nutrition and breastfeeding counseling and referrals for other health care.

Women and children are eligible if their family income equals or is less than 185% of the federal poverty level, which is adjusted annually. For example, a family of four could have an annual income of $27,380 and still qualify. Many working families may be eligible for WIC services and food vouchers but may not know about the program.

In addition to meeting income guidelines, WIC applicants must also have a health or nutrition need. This need is determined by an evaluation of the applicant's hematocrit or hemoglobin level, health history, growth and weight gain pattern, previous pregnancies, diet history and 24-hour food recall. Physicians can assist in eligibility determination by providing hematocrit or hemoglobin levels and other medical data.

Infants born to women who received WIC benefits during pregnancy are automatically eligible for WIC services during the first year of life. This can be a convincing argument for applying for WIC even if the mother is reluctant to seek services for herself.

WIC projects check to make sure that infant and child participants are up to date with recommended immunizations. Many WIC projects work closely with medical and nursing staff so that shots are given right at the WIC clinic. Others refer for immunizations. All provide information and education to parents on the importance of staying on schedule for immunizations.

WIC vouchers can be redeemed at grocery stores and pharmacies for infant formula, milk, eggs, cheese, iron-fortified low-sugar cereals, dried peas and beans, peanut butter and Vitamin C enriched juice. The WIC food package for exclusively breastfeeding mothers was recently expanded to include carrots and tuna fish. This summer, selected WIC projects will also provide vouchers that can be redeemed for fresh produce at farmer's markets.

WIC actively promotes and supports breastfeeding. Data from the Wisconsin WIC Program shows that 41% of WIC infants receive breastmilk as their first food. WIC also provides iron-fortified infant formula for babies whose mothers are unable to, choose not to, or discontinue breastfeeding. To realize the greatest possible savings and thus serve more participants, the state WIC Program has contracted with Wyeth Laboratories to provide SMA or Nursoy formula. Rebates to the Wisconsin WIC Program from Wyeth account for approximately $14 million in 1995. These funds allow the state to serve additional participants. The WIC Program will make therapeutic formulas available when there is a medical reason for doing so. Local WIC projects are eager to work with physicians to assure quality care for their patients.

WIC budget update

- Feb 1995--Gov Tommy Thompson calls for elimination of state support for WIC.
- Joint Finance Committee does not remove authorizing language, but does not include new funds for 1995-97.
- Wisconsin WIC may use $1.2 million in state funds during 1995-97. These funds are carried over from previous fiscal year.
- Budget passed by Legislature requires Wisconsin WIC Program to transfer $334,800 in federal funds from administration to direct services.

At this time, there are a number of congressional proposals that would affect funding, structure and services in the WIC Program. For timely updates, contact the Wisconsin Nutrition Project at (608) 251-4153.

How can physicians help their patients?
Physicians can speed up eligibility determination process for their patients by supplying routinely collected hematocrit or hemoglobin data. It is very helpful when physicians also provide information such as length and weight measurements, gestational age, blood lead levels and information about conditions such as developmental delay, baby bottle tooth decay, failure to thrive, and chronic diseases.

How might all the proposed changes in nutrition programs affect patients?
Currently, Wisconsin serves 70% of the potentially eligible women, infants and children living in the state. Nationally, only 63% of eligible persons are served. Although Wisconsin is doing better than the national record, the fact remains that 30% of needy women, infants and children are not benefiting from WIC foods and nutrition education. Proposals to include WIC in a block grant at the federal level and eliminate state funding for WIC in the governor's budget would limit the program's potential to serve these women and children.

Until state and federal legislation is finalized we cannot know what changes, if any, will be made in WIC eligibility criteria or program benefits. Changes proposed include allowing each state to determine the contents of WIC food packages, quantity and quality of nutrition education and the extent of breastfeeding promotion. This splitting apart of the well-integrated package of health services, nutrition education and food vouchers, that has proved so successful, is of great concern to maternal and child health care providers and advocates.

Over 70 studies have demonstrated that WIC works. The investment made in nutrition services and supplemental foods for pregnant women and children pays off in lower infant mortality rates, fewer babies born at low birthweight, and decreased incidence of childhood anemia. In fact 1 dollar spent on WIC foods for a pregnant woman yields savings of more than 3 dollars in medical care costs for her infant during the immediate past-natal period. WIC is often the gateway to other health services for women and children.

Patients who receive WIC vouchers and the reinforcement of nutrition counseling are found to be more likely to follow their doctor's recommendations regarding optimal nutrition during pregnancy and breastfeeding. Parents of children on the WIC Program are likewise better able to assure adequate nutrition for their children.

Should one continue to refer patients to the local WIC program?
The answer, we at the Wisconsin Nutrition Project believe, is a resounding, "Yes."

Currently, all Wisconsin projects are authorized to serve more participants than are actually enrolled. WIC serves potential participants according to priority. Most pregnant women and infants hold a higher priority than children. Even if waiting lists must be instituted, it is still appropriate to refer patients to WIC because they will be served according to their priority.

During the 1995, the Wisconsin WIC Program is engaged in a major effort to reach eligible persons in working families. Too often, potential participants assume that preventive health programs are meant only for those persons receiving welfare or Aid to Families with Dependent Children (AFDC). This is not the case. Information from the primary health care provider can be crucial. Attitudes toward publicly funded programs may also discourage some persons from applying for WIC. As a physician, your advice is valued. You may wish to counsel patients that obtaining adequate nutrition is an essential component of prenatal care and is cost and health effective in the long run. You can encourage patients to take responsibility for their nutritional well-being by referring them to the local WIC project. Most are located in public health agencies.

For information about WIC in your area, contact the Maternal and Child Health Hotline, 1-800-722-2295. For information regarding the status of WIC and other child nutrition programs in the federal and state budgets, contact the Wisconsin Nutrition Project, Inc. at (608) 251-4153.

Editor's Note: The Wisconsin Nutrition Project, Inc., is a private, nonprofit agency committed to pursuing optimal nutrition and health for all Wisconsin children and families, especially those vulnerable to poverty. WNP carries out its mission through research, education and advocacy.❖

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SMS panel urges non-violent discipline

THE SUB-COMMITTEE ON Domestic Abuse, Commission on Injury, Prevention and Control, was asked as the result of SMS House of Delegates action to develop materials on the discipline of children. The group endorses the list called, "Ten Things To Do Instead of Spanking." We encourage physicians to copy the list and make it available to patients in the waiting area. For more information contact Lynn Sherman, sub-committee on Domestic Violence, SMSW, 330 E. Lakeside, Madison, 53715. The Wisconsin Committee for Prevention of Child Abuse, 214 N. Hamilton, Madison, WI 53703 or (608) 256-3374, has a large library of materials for loan or purchase.❖

Ten things to do instead of spanking

1. **Ignore** Ignore behavior that will not harm them: bad habits, whining, bad language, tantrums. It is hard to do nothing. However, this lack of attention takes away the very audience they are seeking.

2. **Suspend privileges:** Match the suspension of privilege to the action as closely as possible--e.g., fighting over TV brings loss of TV time. Suspend privilege for short periods--long suspensions only build resentment, and the child forgets the original wrongdoing, reducing the effectiveness of the lesson to be learned.

3. **Logical Consequences:** Let the action do the "talking": e.g., abusing the use of a toy means the toy is taken away for a period of time, crayons on the wall are washed off by the "artist," or the amount of time by which a curfew is missed is subtracted from the next outing.

4. **Re-arrange space or place:** Be creative in the elimination of problems: have baskets and low hooks to make room clean-up easier, avoid misplacement of school notes or homework by having a special table or counter for materials, make chores easier to remember by having a chart for who does what and when.

5. **Re-direct behavior:** If one behavior is a problem, channel the energy into another, positive action. Have paper available to avoid crayoning on the wall; give them a ball to throw instead of throwing sand. If they are having trouble taking turns, have them use another toy, or let them help an adult to use up some of the need for power.

6. **Grandma's rule:** When...Then option--when you pick up the toys, then you can have the TV on; when you come home from school on time, then you can have a friend over. Caution: you need to tie what you want with what they want to make this work.

7. **Fines:** In some families, imposing fines (5¢ or 1¢ or 25¢) for bad habits, rules violated, or forgotten responsibilities, does work. Ideally, the "kitty" of money goes for a family outing.

8. **Work detail:** Creative use of energy to "make up" for rule violations is especially effective for children 8 years and older. A list of jobs that need to be done is posted, and the child chooses one or more jobs to "work off" the problem that was created.

9. **Time out**: Use time out for dangerous and harmful behaviors--biting, aggressive hitting, purposeful destruction. Follow these guides:

   - Keep time out to 1 or 2 minutes
   - Have them sit or go to a boring place
   - Tell them what they did wrong and what they are supposed to do instead
   - Use an egg-timer--saves sanity!
   - When time out is over, notice something they are doing right as soon as possible and comment on it.

10. **Praise:** Be specific about praise you give a child for the good things they've accomplished, e.g., "Wow, all the towels are hanging up where they belong in the bathroom, beautiful!"

Developed by MaryLouise Alving, Parents Anonymous, Washington State, edited by the SMS Sub-committee on Domestic Violence and reprinted with permission of the Wisconsin Committee for Prevention of Child Abuse. For helpful information, write: National Committee for Prevention of Child Abuse, Box 2866P, Chicago, IL 60690, or contact the Wisconsin Committee for Prevention of Child Abuse, 214 N. Hamilton, Madison, WI 53703. (608) 256-3374.❖

Dr Hetsko wins seat on AMA Council on Medical Service

Cyril M. "Kim" Hetsko, MD, a Madison internist and past SMS president, is the newest member of the AMA Council on Medical Service. Hetsko won the seat June 21 as the result of an election during the AMA annual meeting in Chicago.

The Council on Medical Service is the AMA body which formulates policy options on socioeconomic issues facing physicians.

"Dr Hetsko's experience in forming a successful physician-owned HMO and his work on numerous state and federal task forces makes him an unusually strong candidate for the council," said SMS President Marcia J.S. Richards, MD. "We are pleased to see Dr Hetsko's election and know he will represent Wisconsin physicians well in the debate on the future of health care in America."

Hetsko will complete the one-year remaining term of John Knote, MD, of Indiana. Knote was elected vice speaker of the AMA House of Delegates during the meeting.

Two other Wisconsin physicians have achieved prominent positions within the AMA. Longtime SMS leader Kenneth M. Viste, Jr., MD, of Oshkosh, serves on the AMA Council on Legislation, the panel that prioritizes AMA issues to be pushed in Congress. Timothy T. Flaherty, MD, of Neenah, serves on the AMA Board of Trustees, the board charged with meshing the recommendations of AMA councils into a coherent legislative action program. ❖

Cyril M. "Kim" Hetsko, MD

Clark County physicians give away trigger locks

New graduates of the Department of Natural Resources hunter safety class have received trigger locks as part of gun safety initiative launched by Clark County physicians.

The Clark County Medical Society recently gave away one tigger lock for each area hunter safety class graduate, as part of its statewide CHILD SAFE program. The goal of CHILD SAFE is to reduce firearm-related injuries and death among Wisconsin youth. On average 80 Wisconsin youth die each year as the result of gun injuries. Demetrio C. Maguigad, MD, is president of the Clark CMS.❖

Society implements Internet E-mail exchange

As a part of our continuing effort to increase two-way communication between staff and the membership, the SMS and SMS Holdings Corporation now have the capability to send and receive electronic mail with anyone who has access to the Internet. We have contracted with a local Internet access provider to supply an e-mail gateway between our internal e-mail system and the Internet. This connection provides e-mail exchange 24 hours per day. In addition to standard e-mail messages, file attachments are also supported. {Note: WordPerfect or ASCII formats are preferred for word-processing documents.}

The Society has been assigned SMSWI.ORG as the Internet domain name and each staff member has an individual address at this domain. In general, this address consists of the first seven letters of their first name plus the first letter of their last name, followed by @SMSWI.ORG. The following is a full directory of SMS/SMSH staff and their respective e-mail addresses:

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If you have questions or comments regarding this service, please contact:
Doug Turecek, M.I.S. Director.
DougT@SMSWI.ORG

❖

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SMS takes positions on health care legislation

THE FOLLOWING LIST OF bills and descriptions has been complied by the SMS Government Relations team as a status report on legislation that the SMS Board of Directors has approved or that has been considered by the Commission on Governmental Affairs.

AB 9 (Carpenter)
Summer externship program funding for Wisconsin Institute of Family Medicine. *Status:* Passage recommended by Assembly Committee on Colleges and Universities. Referred to Joint Committee on Finance. *SMS position:* Support.

AB 36 (Green)
Medical liability reform, including $350,000 cap on noneconomic damages, periodic payment of future medical expenses over $100,000, $150,000 cap on wrongful death awards, modification of collateral source rule. *Status:* Signed into law as 1995 Wisconsin Act 10. *SMS position:* Support.

AB 69 (Johnsrud)
Preempt firearms regulation established by local governments. Passage recommended by Assembly Committee on Criminal Justice. *Status:* Referred to Assembly Committee on Mandates. *SMS position:* Oppose.

AB 83 (Urban)
Increase penalties for battery to an emergency department worker. *Status:* Passed by Assembly and referred to Senate Committee on Judiciary. *SMS position:* Support.

AB 102 (Underheim)
Eliminate Cost Containment Commission Referred to Assembly Committee on Health. *Status:* Passed as a provision of the 1995-97 budget bill. *SMS position:* Support.

AB 141/SB 217 (Urban and Wineke)
Require that a trigger lock be sold with all firearms sold by a federally licensed firearm dealer. *Status:* Public hearing held by the Assembly Committee on Criminal Justice. *SMS position:* Support.

AB 174/SB 90 (Boyle and Risser)
Allows physicians to provide patients with an aid-in-dying for the purpose of ending the patient's life *Status:* Referred to Assembly Committee on Health and the Senate Committee on Judiciary. *SMS position:* Oppose.

AB 196 (Musser)
Relax laws relating to use of ATVs by minors. *Status:* Passed Assembly. Referred to Senate Committee on Environment and Energy. *SMS position:* Oppose.

AB 197 (Musser)
Lower the legal drinking age to 19 so long as federal transportation funding is not jeopardized. *Status:* Public hearing held by Assembly Committee on State Affairs. *SMS position:* Oppose.

AB 227 (Schneider)
Broadens the definition of genetic test to include physical examination or examination of family history; removes prohibition against insurance companies requiring or requesting that insured or prospective insured obtain a genetic test and provide the results of the genetic test. *Status:* Referred to Assembly Committee on Insurance. *SMS position:* Support if amended to retain current law that prohibits insurance companies from requiring or requesting an insured or prospective insured obtain a genetic test and provide the results of the genetic test.

AB 280 (Handrick)
Prohibit non physical therapists from describing the services they render as physical therapy. *Status:* Public hearing held by Assembly Committee on Health. *SMS position:* Support.

AB 286/SB 76 (Lorge and Weeden)
Eases fireworks regulations. *Status:* Referred to Assembly Committee on State Affairs and Senate Committee on Business, Economic Development and Urban Affairs. *SMS position:* Oppose.

AB 292 (Wasserman)
Prohibits insurers from discriminating against victims of abuse or domestic abuse. *Status:* Referred to Assembly Committee on Insurance Securities and Corporate Policy. *SMS position:* Support.

AB 293/SB 144 (Travis and Rosenzweig)
Prohibits possession of firearms by persons subject to an abuse or harassment injunction. *Status:* Public hearing held by Assembly Committee on Criminal Justice. Passage of SB 144 recommended by Senate Committee on Judiciary. *SMS position:* Support.

AB 294 (Travis)
Prohibits sale of firearms by persons subject to an

abuse or harassment restraining order or injunction. *Status:* Referred to Assembly Committee on Criminal Justice. *SMS position:* Support.

AB 304 (Wasserman)
Deletes requirement that attending physician sign certain patient health records if a resident or fellow has attended the patient. *Status:* Public hearing held by Assembly Committee on Health. *SMS position:* Oppose.

AB 399 (Huber)
Simplifies forms for living wills and provides for reciprocity for living wills executed in other states. *Status:* Referred to Assembly Committee on Health. *SMS position:* Support.

SB 11 (Huelsman)
Modifies joint and several liability law so that only those defendants found to be 51% or more negligent can be held responsible for the damage award. *Status:* Signed into law as 1995 Wisconsin Act 17. *SMS position:* Support.

SB 94 (Darling)
Eliminates requirement that physicians secure the consent of the parent or guardian of an infant suspected to have controlled substances in his or her system because of the mother's use of controlled substances. *Status:* Referred to Senate Committee on Health, Human Services and Aging. *SMS position:* Support.

SB 212 (Adelman)
Require driver's licensees and state identification card recipients to indicate their status as an organ donor. *Status:* Referred to Senate Committee on Transportation, Agriculture and Local Affairs. *SMS position:* Oppose.

SB 220 (Panzer)
Requires insurance coverage of five biologically based mental disorders. *Status:* Public hearing held by Senate Committee on Insurance. *SMS position:* Support.❖

SMS to present seminars on health care and the Internet

In September, the SMS will host five seminars on helping physicians and their staff use the Internet. Sessions will include:

- a brief overview and explanation of the Internet;
- hardware and software options for getting connected;
- costs;
- use of the Internet for collaborative research, reference database access, electronic data exchange, global E-mail, on-line services and discussion groups;
- potential implications and uses for the health care industry including claims submissions and videoconferencing;
- security issues; and
- access and implementation issues.

Each session will also have a question-and-answer period. Watch medical society publications for details about dates and locations or call Brenda Whyte, SMS Seminars, at 1-800-362-9080.❖

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CD ROM Review: A look at a new medical resource

R. Zorba Paster, MD, Oregon

Editor's Note: CD ROM Review, an occasional column for the *Wisconsin Medical Journal,* will detail some of the best CD-ROMS that the authors have come across--useful in clinical practice.

EVER WONDER WHAT the latest treatment for Bell's Palsy is? Or if there are any drug interactions between Cimetadine and Lithium? What is the best advice you could give--in light of 1995 information--to a newly married mom who has just had her second spontaneous abortion?

You can find your answers by sauntering down to your local hospital library or by using CD-ROM technology on a nearby personal computer (PC). CD-ROM provides a powerful computer tool, putting the latest information at your fingertips--in your office--at a time when you can best access and make use of it.

A typical floppy disk of 1.44 megabytes holds about 1 000 pages of information; CD-ROM at 600 megabytes holds about 500,000 pages of information, all of it open to information searching. With a minimal outlay of about $1 500, you can purchase a PC or MAC with a double-speed or quad speed CM-ROM reader, the minimum system for speedy exploration.

At first flush, it might look like CD-ROMS are costly. But when compared to CME courses or books such as *Harrison's Principals of Internal Medicine* (priced currently at $98) good CD-ROM packages are cost effective. The issue remains for the buyer to choose wisely. The strength of CD-ROM is the frequency of updates to the information. Updates are often produced annually, thereby making your information a lot more up-to-date than your dusty medical school texts.

A case in point

"So, Doc, why do I have this white stuff in my mouth?"

It was a good question. This 47-year-old married minister clearly had thrush, but why? I immediately thought of diabetes and AIDS--and ordered the appropriate tests to check for them. But, I wondered, was there something I wasn't thinking of? And how long would it take me during a busy day to find etiologies of thrush?

Maybe a CD-ROM could help... The compendium reference I chose was: STAT-Ref! by Teton Data Systems, Jackson Hole, Wyo. (Tel:800-755-7828, Fax: 307-739-1229).

STAT-Ref! is a compendium of books which includes the *Medical Letter on Therapeutics, AMA Drug Evaluations,* the *Current* Series - Such as *Medical Diagnosis, Surgical Diagnosis, Pediatric Diagnosis,* and *Emergency Diagnosis and Treatment, Smith's Urology, William's Obstetrics, Stein's Internal Medicine, Handbook of Drug Interactions* -- the list goes on. They come in packages and just like any other library, the bigger the package, the greater the cost.

Stat-Ref Complete includes 26 headings and is costly at $2 400. I chose the Primary Care Standard for this search. It weighed in at $495--*Six References with one year of quarterly updates.*

Like all CD-ROMs Stat!Ref contains a "Search Engine" which does the actual work of digging out the information. Here's how it goes:

First, choose the titles by selecting either *ALL* or *SOME*. **Comment:** I have found that choosing titles carefully allows you to tailor your search. Choosing *ALL* is good if you have something very unusual and specific, especially if you are unsure where the information is residing. Choosing *SOME* is useful if you know what you are looking for, such as drug interactions, etiology or diagnosis and treatment of a specific disease.

Next choose *SPECIFICITY*. This allows you to specify how your search will occur. Choosing the most restrictive of terms means the words must occur in the exact order, while choosing more general terms moves one up the search tree. For example: If looking for oral candidiasis. If you chose the most specific, you will extract only articles on oral candidiasis. If choosing less specificity, you will extract articles containing candidiasis, not necessarily oral. This will yield more -- sometimes more than you want.

With a bit of practice, though, dialing up the right mix of search parameters becomes a second nature, and within a few minutes (*3 minutes,* to be exact, in this case) I had a nice list of other causes for thrush.

Stat!-Ref had reminded me that oral candida is also associated with dental appliances, spicy food consumption and changes in toothpaste. This may not be Nobel Prize winning information, but I honestly would not have thought of it without Stat!Ref.

What about my patient?

"As a matter of fact, Doc, we just got back from a vacation in Mexico and the food was great! You know, I think my wife got us new toothpaste lately, too." Interesting.

What about Stat!Ref? I'm glad I got it. An excellent tool.❖

This column is not reviewed by the Editorial Board of the Wisconsin Medical Journal. Any products, resources or other materials mentioned in the column are not to be regarded as endorsed by the State Medical Society, nor is the SMS or WMJ responsible for product performance or consumer satisfaction.

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Physician briefs

Marc J. Ackerman, MD, of Mequon, has received the Wisconsin Psychological Association Award for outstanding contributions to the advancement of psychology as an applied profession. He received the award for his contribution to the professional practice of psychology for the past 15 years in three different areas. He served as the dean of the Wisconsin School of Professional Psychology from 1980 to 1987, when it received its regional accreditation; and from 1980 to 1989, he served as the school's director of clinical training. Since leaving his post at the school, he has authored or co-authored four books and one test. His third area of contribution to the professional practice of psychology is serving as the director of psychological services at Charter Behavioral Health Systems in Milwaukee for the past five years.

Steven L. Armus, MD, has joined the staff of the Mercy Lake Geneva Medical Center. A graduate of the University of Wisconsin Medical School, Dr Armus completed post graduate training at Columbia Affiliated Hospitals and Morristown Memorial Hospital in New Jersey. His residency training in dermatology was completed at the State University of New York at Buffalo. Dr Armus is a member of the American Academy of Dermatology, the AMA, and the Wisconsin Dermatology Society.

Anthony H. Balcom, MD,* has been appointed chair of the Department of Urology at Children's Hospital of Wisconsin. A 1984 graduate of the Medical College of Wisconsin, Dr Balcom finished his urology residency at the Medical College of Wisconsin Affiliated Hospitals in 1989. He then did a fellowship at the Toronto Hospital for Sick Children in pediatric urology from 1989 through 1990. Certified by the American Board of Urology in 1992, for both pediatric and adult urology, Dr Balcom became a fellow of the American Academy of Pediatrics, Urology Section in 1994. Dr Balcom is co-founding an enuresis clinic at Children's Hospital of Wisconsin and attempting to form a society for biofeedback and electrical stimulation therapy techniques, specifically related to the bladder and pelvic floor.

Paul Carbone, MD,* director of the UW Comprehensive Cancer Center, has been elected chair of the Wisconsin Cancer Council, a coalition of 24 organizations dedicated to developing and coordinating a comprehensive, statewide cancer control program. Dr Carbone, a UW Medical School professor and UW Hospital and Clinics medical oncologist, has led the Council for eight of the last 10 years.

Robert Freedland, MD,* has joined the ophthalmology department at Skemp Clinic. He received his medical degree from the University of California-Davis, and is a member of the American Academy of Ophthalmology and the AMA, and serves on the American Board of Ophthalmology and the National Board of Medical Examiners.

Christopher J. Keller, MD, will join Ear, Nose & Throat Associates of Manitowoc on July 31. He obtained his medical degree from the University of Wisconsin School of Medicine. He will complete his specialty training for otolaryngology at the University of Vermont. He is a member of the American Academy of Otolaryngology .

Gerald C. Kempthorne, MD,* has been promoted to the position of vice president of medical affairs at the Wisconsin Physicians Service Insurance Corporation. He will oversee the management of WPS programs in care management, quality improvement, pharmacy benefits, healthcare information, provider reimbursement, medical review, corporate health nursing and health enhancement. Dr Kempthorne is a

AMA Awards

The Wisconsin physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates members of the SMS.

* Banker, Vincent P.
Biehl, Mark D.
* Bollom, Steven J.
* Devermann, Robert B.
* Dralle, William G.
* Duenk, Larry L.
* Griebel, Craig P.
* Lingen, Thomas A.
McGinnis, Kathleen J.
* Robertson, Russell G.
* Rose, Quentin F.
Salisbury, Steven M.
Sherman, David M.
* Walters, William V.
* Whitworth, Anne B.
* Wilson, Janet A.❖

past president of the State Medical Society and served for 10 years as the first medical director for HMO of Wisconsin. He practiced family medicine in Spring Green for more than three decades.

Lowell Kristensen, MD,* has retired from the Marshfield Clinic-Indianhead Center, following a career spanning nearly 40 years as a family practitioner. Dr Kristensen earned his medical degree from Yale University in New Haven, Conn. He completed a family practice internship at Ramsey County General Hospital in St Paul and worked five years in Chetek before moving to Rice Lake.

Rose M. Kumar, MD, has joined the Memorial Hospital at Oconomowoc medical staff, specializing in internal medicine. Dr Kumar received her medical degree from the Albert Einstein College of Medicine in New York, and completed an internship in internal medicine at the University of California in San Francisco. She completed her residency in internal medicine at Stanford University Medical Center. She was an internist and director of the ReadiCare Urgent Center in Sacramento, Calif, and most recently served as director of the Mercy Lake Geneva Medical Center.

Roland Liebenow, MD,* and his wife, Martha, have been chosen as the Lake Mills Festival Days parade marshals because of their community service and involvement with the city. Dr Liebenow was in private medical practice, including obstetrics, from 1950 to 1967. He was also a member of the SMS Committee on Aging and Extended Care Facilities, serving as chair from 1983 to 1986. He was also on the Federal Legislation Committee from 1981 to 1987.

V. K. Nair, MD,* a urologist at The Monroe Clinic, was recognized by the department of surgery at the University of Wisconsin Medical School for his clinical and teaching contributions. He has been associated with the UW program for 20 years and was reappointed as a clinical assistant professor for a term ending June 30, 1996.

Katherine Parkinson, MD, has joined the Duluth Clinic-Ashland as a board-certified dermatologist. Dr Parkinson received her medical degree from the University of Missouri in 1989. She did her internship at Hennepin Medical Center and completed her residency in dermatology in 1993 at the University of Minnesota, where she served as chief resident during her last year.

Roland A. Pattillo, MD, professor of obstetrics and gynecology at the Medical College of Wisconsin, was honored at a retirement reception in June. He is one of the world's leading researchers in gynecologic cancers, and is currently president elect of the Society of Gynecologic Oncology of the Midwest. A 1959 graduate of the St Louis University School of Medicine, Dr Pattillo did research at the Medical College of Wisconsin, where he was an intern and resident in obstetrics and gynecology. He continued research as a postdoctoral fellow at John Hopkins University from 1965 to 1967, before returning to the Medical College in 1968. In his semi-retirement, he plans to teach on the faculty of Morehouse University School of Medicine and provide indigent care.

Mark Rosen, MD,* a Bayside urologist and assistant professor of surgery in the division of urology at the Medical College of Wisconsin, has been awarded a Career Development Award from the American Cancer Society, given annually to physicians who show promise in medical practice and research related to oncology. Before joining the Medical College faculty last year, he was an instructor in urology and an American Foundation for Urologic Disease Research Scholar at the University of California, San Francisco. He served a residency in urology at Baylor College of Medicine in Houston and an internship and residency in general surgery at Harbor-UCLA Medical Center in Torrence, Calif. He is a graduate of UCLA School of Medicine.

Peter G. Van Oosten, MD,* an obstetrician and gynecologist at Two Rivers Clinic, is currently seeing patients at the Two Rivers Clinic and its satellite office in Michicot. A native of Detroit, Dr Van Oosten received his medical degree at Michigan State University in 1982. He completed his residency in obstetrics and gynecology at Oakwood Hospital in Dearborn, Mich. He is certified by the American Board of Obstetrics and Gynecology.

Paul K. Wegehaupt, MD, FAAP,* has joined the Rhinelander Medical Center Pediatric/Adolescent Medicine Department. He earned his medical degree from the University of Illinois in Chicago and completed his residency at the University of Oregon Health Science Center in Portland. He was in private practice at Suburban Medical Clinic in Portland until 1987. He had been with the Indian Health Service-US Public Health Service in Rhinelander and Milwaukee. ❖

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State Legislature wraps up budget; health care provisions detailed

For the first time in 25 years, Republicans were in total control of determining the state's spending priorities for the upcoming two state fiscal years. Unlike two years ago when health system reform was on everybody's agenda, property tax relief was the number one theme on legislators' minds as they sent the final version of Assembly Bill 150 to Gov Thompson's desk before the July 4 holiday weekend. The following is a summary of issues relating to medicine:

The SMS was successful in removing a $300 physician license tax from Gov Thompson's original budget proposal which would have been used to fund property tax relief and physician Medicaid rate increases.

The cigarette excise fee will increase only 6 cents over the next two years. The SMS, along with the American Heart Association, American Cancer Society, and American Lung Association pushed for a 50-cent increase to help address the state's need for additional revenue and at the same time reduce youth cigarette consumption.

The SMS convinced the Legislature to include a provision requiring the Department of Health and Social Services to convene a study committee to investigate standardizing Medicaid managed care forms, such as prior authorization and referral forms. This was one of the recommendations contained in the Medical Society's Urban Medicine Task Force report. This will have a broader impact given the imminent statewide expansion of the Medicaid HMO program next year.

The Legislature made no changes to Gov Thompson's proposal to expand the Medicaid HMO program statewide for all AFDC recipients, now in the planning stages.

The SMS also worked with the Medical College of Wisconsin and the UW Medical School to remove a provision which would have required both medical schools to tie tuition capitation payments to student income. This would have resulted in increased debt load for medical students and, as studies have indicated, probably discouraged graduates from choosing a career in primary care.

Also contained in the budget is an item that will prohibit the renewal of professional licenses, including physician licenses, by the Department of Regulation and Licensing if the individual is liable for any delinquent state taxes. License holders will be notified prior to denial and will have 30 days to request a review. This policy will take effect with credentials that expire on or after Jan 1, 1996.

Gov Thompson is expected to sign the budget bill by the end of July and, unlike previous budgets, make few vetoes.❖

SMS asks state officials to stop imposing sales tax on medical records

In response to several complaints the SMS has received from physicians and clinics about the Department of Revenue's target audits, SMS Executive Vice President Tom Adams, CAE, wrote to Department of Revenue Secretary Mark Bugher urging reconsideration of the position that requires physicians who charge for photocopying medical records to also collect sales tax. Adams wrote, "The `true objective' of patients who patronize a physician's office is to obtain medical services, not to purchase photocopies. The transfer of the photocopies is only incidentally involved in the performance of medical service." As such, photocopying medical records should be exempt from the sales tax requirements, he stated. The DOR will complete its pilot audit in July, after which, a statewide audit will be conducted. Adams' letter is also intended to dissuade the DOR officials from imposing penalties against physicians who have not collected sales tax on photocopies in the past. If physicians or clinics have concerns or questions regarding the target audit, contact Craig Johnson at the DOR at (608) 266-7166.❖

County society news

Dane. The Dane County Medical Society approved membership for the following physicians: Joseph A. Bellissimo, MD; Andrew J. Bernstein, MD; Ralph B. Blasier, MD; Robert C. Buss, MD; Kamal Chaban, MD; Patricia A. Cosgrove, MD; Linda M. DeLessio, MD; Sandra I. Engelhardt, MD; and Thomas J. O'Brien, MD.

Green Lake-Waushara. David Eric Swanson, MD, has been accepted into the Green Lake/ Waushara County Medical Society.

Kenosha. The Kenosha County Medical Society approved membership for Nicholas A. Akgulian, MD.

Marathon. Membership in the Marathon County Medical Society has been approved for Margaret D. Anderson, MD; and Jeffrey S. Oswald, MD.

Outagamie. The Outagamie County Medical Society approved membership for the following physicians: William R. Hathaway, MD; Michele A. Holder, MD; Michael F. Maguire, MD; and James V. O'Leary, MD.

Pierce-St. Croix. The Pierce-St. Croix County Medical Society met at Joseph's Restaurant in New Richmond on Tuesday, June 20, 1995. The guest speaker was an otolaryngologist sponsored by Mead-Johnson. Membership was approved for Marvin Klinger, MD.

Racine. The following physicians have been approved for membership in the Racine County Medical Society: Pamela J. Butler, MD; Donald M. Garland, MD; Farhat N. Khan, MD; George A. Pagels, MD; Lucia M. Ricci, MD; and Suzanne I. Starkey, MD.

Rock. The Rock County Medical Society approved membership for Mark McDade, MD.❖

Obituaries

Bringe, James W., MD, died May 24, 1995, in Sheboygan. He was born July 17, 1915. He obtained his medical degree from the University of Wisconsin, Madison. His preceptorship included rotations at Columbia Hospital, Milwaukee, Marshfield Hospital, Marshfield, and Chicago Lying-In Hospital in Chicago. He studied dermatology at the University of Wisconsin and finished his residency at the University of Michigan at Ann Arbor. He served in WW II in the US Army and was stationed in the Philippine Islands. Dr Bringe was a doctor of dermatology in Sheboygan for 41 years, before retiring in 1993. He also had an office in Manitowoc from 1955-1970. He was a life-member of the American Academy of Dermatology, the Chicago Dermatology Society, and served as president of the Wisconsin Academy of Dermatology and did a fellowship at the Skin Cancer Foundation. He was also a member of the State Medical Society, the medical staff at St Nicholas Hospital, Sheboygan Memorial Medical Center, and Holy Family Hospital, Manitowoc. Dr Bringe is survived by his wife, Marjorie.

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.❖

Cary, John F.,"Jack" MD, died May 11, 1995. He graduated from Loyola University of Chicago Medical School. He was an Army veteran of WW II, serving as a surgeon for a mobile field unit during the Battle of the Bulge, and was awarded the Bronze Star for bravery. Dr Cary

served as chief of staff at St Luke's Hospital from 1959 to 1969. He was instrumental in the opening of St Luke's emergency room and following his retirement in 1976 after 30 years of practice in the Milwaukee area, worked part time in St Luke's emergency room until the early 1980's. Dr Cary is survived by three sons, Robert of New Orleans, Thomas of St Francis, and John of Mequon.

Donkle, Milton Judson, MD, died June 6, 1995, in Portage. He was born September 2, 1907. Dr Donkle received his medical degree from the University of Illinois College of Medicine. He completed post graduate work in pathology at Cook County Hospital, Chicago, followed by an internship at Augusta Hospital in Chicago. He started general practice in Oshkosh in 1935. He served as a pathologist at Mercy Hospital and Theda Clark Hospital, Neenah-Menasha, and at St Elizabeth's Hospital in Appleton. Dr Donkle served in the Army Medical Reserve from 1936 until he was called to active duty in the Guadacanal and North Solomon Islands campaigns. After being honorably discharged in 1945, he resumed general practice in Janesville. He was a member of the AMA, State Medical Society, and Rock County Medical Society. He is survived by his children, James Byron Donkle, MD, Milwaukee; Judy Ann Masat, Davenport, Iowa; and stepchildren, Charles Knipp of Monona, Carol Dixon and Michael Knipp, both of Edgerton, Rosemary Schaller of Rhinelander, and Harry Knipp of Racine; five grandchildren; ten step grandchildren; four great-grandchildren; and two step great-grandchildren.

Golden, Farrell F., MD, died March 14, 1995, in Middleton. He was born March 4, 1915. Dr Golden graduated from the University of Wisconsin Medical School in 1941. He interned at Akron City Hospital in Akron, Ohio. He served in the US Navy from 1942 to 1946. He served a residency in radiology at City Hospital in Akron, Ohio and at the University of Pennsylvania's Philadelphia General Hospital. Dr Golden practiced radiology at Mercy Hospital in Oshkosh and Theda Clark Hospital in Neenah. He practiced in Ashland, Wisconsin and Ironwood, Michigan from 1949 to 1950, before practicing at Dean Clinic in Madison from 1950 to 1970. He was head of the Radiology Department at Watertown Memorial Hospital from 1950 to 1980, and head of the Radiology Department at Divine Savior Hospital in Portage, Wisconsin from 1950 to

Continued on next page

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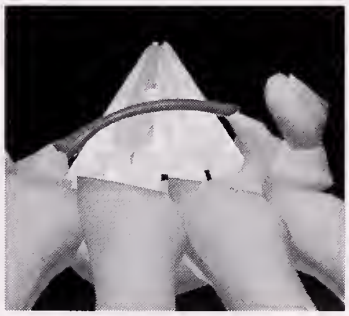

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1983. He was consultant radiologist at UW Hospital and Clinics from 1984 to 1985. Dr Golden was a member of the State Medical Society, Dane County Medical Society, Wisconsin Radiological Society, American College of Radiology, where he was elected to a fellowship in 1961, and the Radiology Society of North America. Dr Golden is survived by his wife, Marjorie; two sons, John of Madison, and Dan of Emerald, Wisconsin; seven grandchildren; one sister; and one brother.

Hahn, Warren V., MD, died February 15, 1995. He was born January 17, 1921. He graduated from Marquette Medical School in 1950, and did his internship at Mercy Medical Center. He was a WW II Army veteran. He was a member of the Mercy Medical Center staff from 1951 until his retirement in 1985. He was employed as a physician's representative for the Oshkosh Area Physician's Association-HMO Wisconsin. Dr Hahn was a member of the Winnebago County Medical Society, and the State Medical Society. Dr Hahn is survived by his wife, Olive, of Oshkosh; a son, Michael of San Diego, Calif; and a sister.

Hobson, WS (Stan), MD, died January 24, 1995, in Ft Walton Beach, Fla. He was born July 10, 1925. He served in the US Army during WW II, and graduated from the UW Medical School and interned at Milwaukee Hospital. He practiced in Chilton, Wisconsin for one year before moving to Sturgeon Bay in 1957. He retired in 1987. Dr Hobson was a member of the State Medical Society, and the Door-Kewaunee Medical Society. He is survived by his wife, Carol; a son and daughter-in-law, Barry and Naomi, Appleton; and a grandson.

Nezworski, Louis G., MD, died April 8, 1995, in Scottsdale, Arizona. He was born November 8, 1912. He graduated from Marquette University Medical School in 1942, specializing in pulmonary diseases. Dr Nezworski interned at St Mary's Hospital in East St Louis, Illinois, and at the Middle River Sanitarium in Hawthorne, where he also completed his residency. He served as medical director of Mt Washington Sanitarium in Eau Claire until 1978. He was an instructor at the Luther Hospital School of Nursing in Eau Claire, and worked in student health at the UW-Eau Claire. He was also an occupational health physician at Uniroyal Rubber Company in Eau Claire and was on the medical staff of both Luther Hospital and Sacred Heart Hospital. He retired from full time practice in 1978. He was a fifty year club member of the State Medical Society, a member of the Eau Claire-Dunn-Pepin County Medical Society, and a Fellow of the American College of Chest Physicians. Dr Nezworski is survived by his wife, Stella; a daughter, Katherine Granger of Scottsdale, Arizona; two sons, George of Neillsville and Joseph of Eau Claire; a sister; and four grandchildren.

Ohme, Donald D., MD, died June 18, 1995, in Antigo. He was born September 27, 1941. Dr Ohme received his medical degree at the University of Illinois, Chicago, and completed his internship at Cook County Hospital. He completed a residency in surgery at Cleveland Clinic Foundation, Cleveland, Ohio. He joined the Sheboygan Clinic in 1975. He was on the staff at the Sheboygan Memorial Medical Center, St Nicholas Hospital, and Valley View Medical Center. Dr Ohme was a Fellow of the American College of Surgeons and was a member of the Wisconsin Surgical Society, Sheboygan County Medical Society, where he served as historian, State Medical Society, and AMA. Dr Ohme is survived by a son, Hans, Ketchum, Idaho; and two daughters, Kristin and Karin, both of Sheboygan.

Spankus, Jack D., MD, died April 15, 1995, in Glendale. He graduated from Marquette University Medical School and interned at the VA Hospital and Jefferson-Davis Hospital in Houston, Texas. He was a resident in general surgery at Columbia Hospital in Milwaukee and served an Orthopedic Surgery Residency at Wood Hospital, Columbia Hospital and Milwaukee Children's Hospital. He was a member of the Medical Society of Milwaukee County, State Medical Society, Academy of Orthopedic Surgeons, and Clinical Orthopedic Society. Dr Spankus is survived by two sons, Mark of Madison and John of Florida; a daughter, Martha of Milwaukee; and a brother.

Taft, Donald J., MD, died April 9, 1995, in Richland Center. He was born on May 27, 1912. He graduated from Marquette Medical School in Milwaukee and did his residency at Gorgas Hospital, Ancon, Panama Canal Zone. Dr Taft practiced medicine in Richland Center for 32 years. He was a member of the 50 year club of the State Medical Society, a past president of the Richland County Medical Society, and the AMA. He is survived by his children, Dr Stephen Taft, Stevens Point; Dr Sheila Taft Fitzgerald, Reston, Virginia; Laura, Georgetown University; and Rachel Taft Pontzer, Plymouth, Minn; and four grandchildren.

Traul, Don G., MD, died May 5, 1995, in Monroe. He was born July 7, 1938. He graduated from Ohio State University Medical School in 1964, and was head of the department of colon and rectal surgery at the Monroe Clinic from 1973-1994. He was a member of the American Cancer Society, the Monroe Clinic Foundation, and he served as chairman of the Monroe Clinic Executive Committee. He received the AMA Physician Recognition Award in 1971. Dr Traul was a captain in the US Army Medical Corp, commander of the armed forces examining station, medical section, Albuquerque, NM, and

served as a battalion surgeon with the 3/6 Artillery in Vietnam, where he was awarded the Bronze Star with "V" Device and the Bronze Star "First Oak Leaf Cluster." Dr Traul is survived by his wife, Bobette, of Monroe; his mother, Marie J. Traul, Columbus, Ohio; two sons, Donald, Colorado, and David, Milwaukee; one stepson, Francis Donny, Philadelphia, Pa; two stepdaughters, Wendy Killeen, Cleveland, Ohio, and Jennifer Greenwald, Philadelphia; one brother; one sister; and three grandchildren.❖

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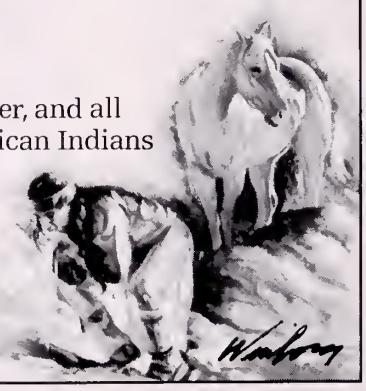

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Malnutrition in the elderly

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Wisconsin Medical Journal

The *Wisconsin Medical Journal* (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor and editor are responsible for overseeing the production, business operation and contents of the journal. The editorial board, chaired by the medical editor, solicits and screens all scientific, special and soundings articles; it does not screen socioeconomic or organizational articles. The chair provides leadership for the editorial associates and comments on both editorials and letters to the editor. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *WMJ* nor the SMS take responsibility. The *WMJ* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

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State Medical Society of Wisconsin

Created by the Territorial Legislature in 1841 and now representing nearly 8,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal*.

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President's page
Politics is not a dirty word; it's reality

"Those who are too smart to engage in politics are punished by being governed by those who are dumber."
--Plato

I'D LIKE TO THINK that Plato made this statement because he found it necessary to encourage his colleagues to be politically involved. How I wish I could tell him that times have changed!

When we look at WISPAC, our political action committee, or Physicians for a Better Government, our conduit, based on a member political activity of only 7.4% (fig 1), we would conclude that the term "political action committee" is an oxymoron. Optimal effectiveness is difficult with so few truly committed individuals.

Of course our membership dues contribute to lobbying efforts by SMS staff on our behalf. But reality is that "hired guns" need reinforcements from the ranks to have maximal effectiveness and credibility. This scenario took me some time to appreciate, and even longer to accept and act on, as I was raised in the middle-class, middle of the road, moderately conservative Midwest family whose entire political activity consisted of showing up at the polling booths on election day. I was not raised to be at ease with the political process. In fact, I used to, and occasionally still do, find it downright uncomfortable.

But in the real world at the interface between the physician and society, politics changes the course of medicine. No more clearly can this be seen on a broad scale than with the recently sweeping health care reforms proposed by the Clintons, and now the efforts to re-engineer Medicare. But many political decisions that have an impact on our profession are painted with a much smaller brush, like Serat, the pointillist French impressionist, whose dots of paint on canvas ultimately created a changed landscape.

Marcia J. S. Richards, MD

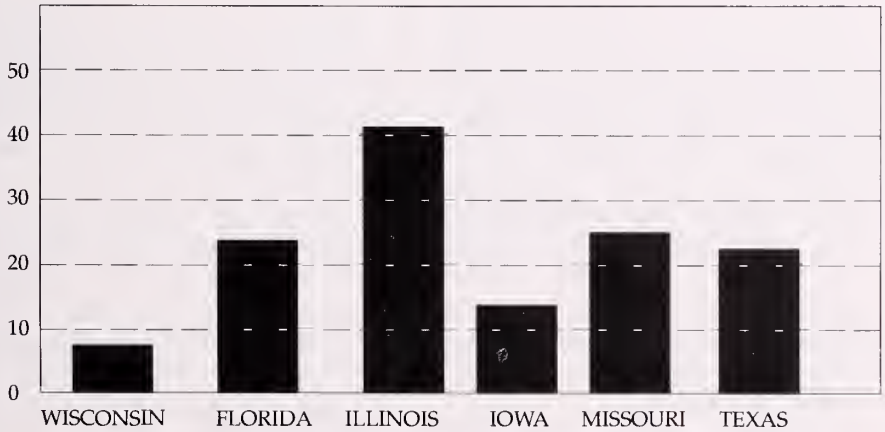

Fig 1--National PAC comparison of percentage of state society members who give to PACs. Wisconsin 7.4% of SMS members give to WISPAC; Florida 23.8%; Illinois 41%; Iowa 13.8%; Missouri 24.1%; and Texas 22.1%.

As physicians, we know the importance of preventive medicine. We do not, however, practice preventive politics well, i.e. by getting involved before there are problematic issues under consideration in Madison or Washington.

Involvement requires knowing

your political representatives at state and national levels, and letting them get to know you. Involvement requires giving a little of both time and money. What we have learned in medical practice can also be applied to politics: efforts and costs are often less if action is taken *before* there is a problem to correct.

Fortunately your SMS makes political involvement easy and convenient through two vehicles, neither of which I understood when I first joined. Some of you may also have a similar knowledge void.

The first is WISPAC (Wisconsin Physicians Political Action Committee), which is governed by a Board of Directors who interview candidates with a special emphasis on issues important to medicine. After an interview process (open to all members), WISPAC endorses candidates and disperses funds from the collective coffer. Any member of WISPAC may contribute to this process. Because of certain procedural restrictions, these recommendations must be communicated on SMS stationary, something that has not been understood by all members.

Recently I received feedback on an endorsement made by WISPAC from a significant number of SMS members in the candidates' district. I was pleased with their political awareness, but wish that at least as many in the district had been members of WISPAC and could have been active prospectively, rather than retrospectively.

A sister political organization is Physicians for Better Government. Here a contributing member retains the right to decide where their dollars are sent. This is a win-win situation since many of us would (or at least should) support candidates for state offices. But with a conduit route, both you and your profession benefit and receive credit for your contribution. This is like a two-for-one sale. How can you or medicine go wrong?

Now what's the downside? You must personally make the contribution since your accountant, secretary, clinic or business manager can't write the check for you for these line items on your dues statement. In fact, your staff might not even mention that you have the opportunity to contribute to these political efforts on your behalf. In other words, becoming active in WISPAC or Physicians for Better Government is as hard as paying the electric or gas bill; except that you only have to write a check once a year.

Other professionals' contribution patterns are shown (see figures 2 and 3) for the 1994 elections. When I saw these numbers I understood better why we, as physicians, sometimes have difficulty getting a sympathetic ear in the halls of government. Perhaps some of the rest of you will also be shocked by Wisconsin physicians' level of political commitment.

Please don't assume someone else will do the job it you fail to contribute. Please get out your pen, write out a check for $50, $100 or $200 and join. Medicine needs more than ever to be active in the political decision making process. The course of American medical practice is changing, as both industry and government encourage and legislate the use of managed care. ❖

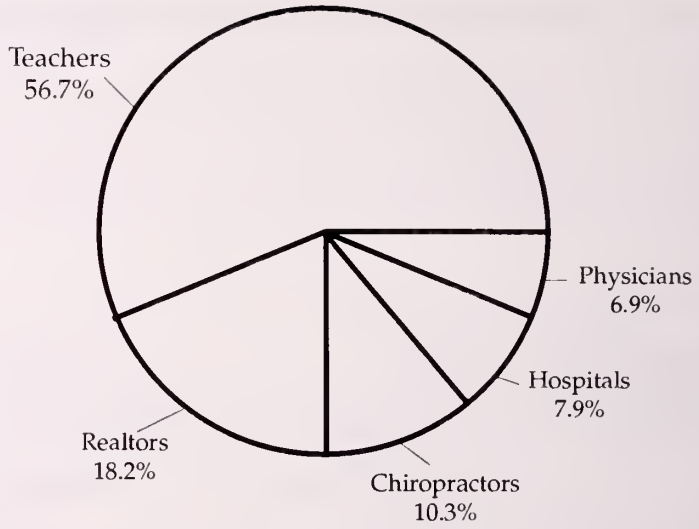

Fig 2--Total PAC/conduit contributions for the 1994 election. Teachers $552,573 (53,489 teachers); Realtors $177,639 (10,755 realtors); Chiropractors $100,021 (1,200 chiropractors); Hospitals $76,870 (8,500 potential donors); and Physicians $67,752 (11,347 physicians).

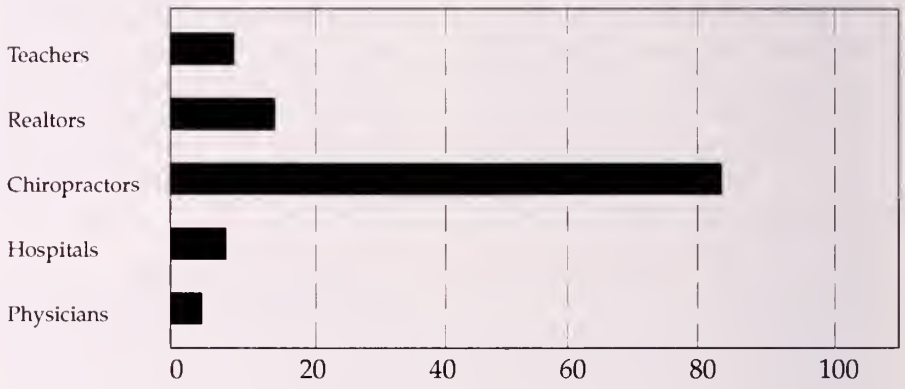

Fig 3--Dollar amount contributed per member for the 1994 election. Teachers $10.33; Realtors $16.51; Chiropractors $83.35; Hospitals $9.04; and Physicians $5.97.

EVP report: The view from here
State government 'walking the walk'

Don't talk the talk if you can't walk the walk.
--Author Unknown

POLITICAL POSTURING as an art form has stood the test of time. Each new political administration, albeit federal or state, brings with it ideas for making our lives "better" and "improving" government. Four years later (when our lives have gone for the most part unchanged), we'll either buy into a new set of promises or we'll gratefully vote the same people back in, based on the belief that "They didn't do much, but at least, they didn't make things worse."

Yet, of late, I've observed a paradox operating within our government. All eyes are focused on Washington where Newt Gingrich and Company are busy talking about how they are changing the world. But at the end of the 100-day honeymoon for the new Republican gang, what can they truly point to as accomplishments? For all their good intentions, they've been mired by the quicksand that consistently clogs the workings of Congress, particularly the U.S. Senate. It remains to be seen if the Senate confirms the revolution that occurred in the House, and if the president will concur.

Here on the homefront, meanwhile, there has been less talk about doing and more doing than talking.

The Wisconsin Legislature, controlled for the first time in 25 years by Republicans, is walking the walk that Washington to date is only talking. Five major bills were passed in the first 30 days. Things that have been put off, put down and flat out ignored, have been considered, contested and corrected. I believe they call that progress, folks!

While they were talking a good game in Washington, look what the Legislature was **doing** in Wisconsin. Our state:

- passed a major tort reform package limiting non-economic damage awards in medical liability lawsuits to $350,000;
- passed joint and several liability reducing the ability for litigants to "go for the deepest pocket";
- adopted legislation approving operation of the University of

Continued on next page

Thomas L. Adams, CAE

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Continued from preceding page

Wisconsin Hospital and Clinics as a new public-private authority and moving 1,868 workers off the state payrolls;

- took the first steps toward a major reorganization (and hopefully) more efficent state government; and
- created a separate department of health-- so public health issues no longer must be juggled against welfare concerns.

Benjamin Disraeli once noted: "Change is inevitable. In a progressive coutry change is constant." Wisconsin--long known outside our borders as a progressive state--is continuing to charge forward. Our state government is listening to its people and we are beginning to see thoughtful changes made through the legislative and regulatory processes. We can look at specific legislation and feel good about the contributions we have made toward better health care delivery in our state.

I met recently with legislative leaders and was told they intend to continue to take the bull by the horns. Instead of leaving the path clear for manipulation by special interests, they have established a firm legislative calendar, setting dates when specific issues will be addressed. The gloves are off; it's a no-nonsense approach to initiating change. Members of both parties have been put on notice that the important issues aren't going to slide by this time; issues will be discussed and action taken. For example: Sept. 18 has been set aside for the Brewer stadium proposal; Sept 20 will be the day for discussion and action on welfare reform and Sept 27 has been slated for discussion and action on health care legislation. Other issues for which the majority leaders in both houses have already established special days for condieration and action include: transportation, parents' rights, gun owners' rights and the right to farm.

So while the "movers and shakers" in Washington keep talking, we've got to also keep our eyes on those "talking and walking" close to home. Government in Wisconsin is not paralyzed; it's striding out to meet the challenges of the 1990s. ❖

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Editorial
Nutrition and the elderly

Laura Vailas and Susan Nitzke do a good job of reassuring readers that not too much has changed in picking up signs of malnutrition in the elderly (see page 495), but they remind us of the valuable contributions N51 has made toward heightening awareness of the need for nutrition screening in older individuals. Furthermore, they provide a copy of a convenient checklist which was developed by the Nutrition Screening Initiative and is easily reproducible for use with elderly patients.

I was interested to see what it took to get a copy of the 5-hour home study course and what constituents the course are. As with anything to do with the unknown agencies (the Nutrition Screening Initiative is a collaborative effort of the American Academy of Family Physicians, American Dietetic Association, and the National Council on the Aging), I kept notes of my actions and their promises. I must tell you that I have not been successful in obtaining a copy of the publication from the Nutrition Screening Initiative despite the promises in response to my telephone requests on July 12, 20, and 27, though they did fax me a copy of the order form in response to my somewhat testy third request. To my surprise, I was asked to return the order form to Nutrition Screening Initiative, P.O. Box 1960, Maple Grove, MN, 55369-0058, but it didn't surprise me when the order form suggested I allow 6-8 weeks for delivery for the $10 publication.

Since I wanted to give interested readers some view of the publication, I was fortunate to obtain a copy of "Incorporating Nutrition Screening and Interventions into Medical Practice" from Ms. Vailas.

Is the publication worth getting? Yes and no, but more yes than no. Why yes? It has useful definitions, lists of malnutrition related conditions and prevalence data by age, provides Level I and Level II screens, nomograms for body mass index to give some idea of when to get excited, and does give some community organizations that can help. Equally it points out 1994 CPT codes for nutritional services.

Why no? Mainly my own idiosyncrasies. There are at least six of those complex matrices that seem to be the love of all nutritionists. Each matrix has 32 boxes on the single page with minute printing, the most frequent of which is "all prior interventions." So, on one page we have four idiot lists for what everyone should do for the patient - from family and friends to dentists, psychiatrists and physicians. All very useful, but not for me. However, the other 60 pages of the publication are well worth having - if you can extract a copy from either Washington or Minnesota.

Thomas C. Meyer, MD

--Thomas C. Meyer, MD
Medical editor❖

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Letters
More on Marshfield

To the editor: The decision of the State Medical Society of Wisconsin to offer an amicus brief on behalf of the Marshfield Clinic represented a political and ethical mistake of the first order. A society which is purported to represent all its physician members cannot support one group of members, interests against those of another. That case was well-articulated at the State Medical Society annual meeting in April. The well-organized opposition of the Marshfield Clinic and their supporters in the leadership of the State Medical Society were successfully able to defeat any attempts to resist the filing of an amicus brief. The short term interests of the Marshfield Clinic have been met, but the long term interests of the State Medical Society may have been hurt.

I have had the opportunity to read the amicus brief in totality. I feel this document is reasonably shallow and not a convincing argument. It was hardly worth the "political capital" that the State Medical Society has lost by going against the interests of its small independent members. It was chilling to see the leadership of the State Medical Society fall in ranks behind the interests of a large physician group. Should the State Medical Society be retitled "The Group Practice Association of Wisconsin?"

It is not too late to address some of the concerns of the considerable portion of the membership which did not agree with the filing of the amicus brief. The objections of those of us who disagreed were not so much against supporting the concept of physicians organizing, as against the egregious charges of unethical physician to physician conduct. Since the State Medical Society has chosen to bring forward the issue of the amicus brief, it also behooves the Society to fully investigate the ethical charges against the Marshfield Clinic. Members of the State Medical Society have allegedly suffered substantial mistreatment by the Marshfield Clinic. An ethical investigation of these charges by the State Medical Society is mandated by the mere fact that this whole issue has been brought to the House of Delegates.

It makes little difference to me as a physician whether I am being bullied, coerced, intimidated and controlled by a large group that is run by insurance executives or my fellow physicians. If the State Medical Society loses focus on who they represent and why they exist, the future of this organization is in question. Mr Adams in his EVP Report in the last issue of the *Wisconsin Medical Journal* advised us not to be a "house divided against itself." It is certainly hypocritical of the leadership of the State Medical Society to lecture us as members regarding working against our own interests while the leadership of the society is comfortable to bring this divisive issue to the House of Delegates and place undue pressure to pass the resolution on the members present. The State Medical Society should have stayed out of the Marshfield Clinic case completely. The society has no business taking an advocacy position of any form when one group of members are in conflict with another group of members. I support Doctor Mayersak in his comments in the last issue of the *Wisconsin Medical Journal*. I hope the State Medical Society will rise to the challenge of addressing the ethical and professional issues involved in this case, and not confine itself to the narrow political and financial issues addressed in the amicus brief.

--Ron H. Stark, MD
Milwaukee❖

Opinion policy

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Tort reform converts

To the editor: I read with great interest the article, "Searching for Words to Describe the Moment," by Terry Hottenroth, JD. In discussing the thoughts about a headline to describe the passage of the tort reform bill, I was struck with mixed feelings. Certainly I cannot deliver sufficient statistics to the extent as those involved in studying and lobbying the issue of tort reform for medical malpractice. However, I see through my own rose-colored glasses as I treat people with physical and cognitive disabilities on a daily basis. As a physiatrist practicing my specialty for the past 14 years, I have had the pleasure of being involved in helping many people with severe disabilities. My path has taken me into the treatment of individuals with spinal cord injuries, brain injuries and chronic pain. In these conditions, the goal of treatment is to put peoples' lives back together after total disruption the specific pathology causes. Through my own personal view, I see the initial destruction, and the hard-fought battles people undertake to again find a sense of relative happiness and productivity in their lives. During my many years of experience, it seems to me it is hard to place a dollar amount on how these problems affect the individual person, their immediate family and the community at large. Therefore, I have no ability to debate whether $350,000 is a reasonable amount of money or not. However, what is clear in all liability issues related to people's health is the amount of money people recoup is almost never enough in relationship to problems incurred.

To read this article where one assumes doctors and patients win and lawyers lose is definitely not something I would agree as a statement ot totality. As a physician treating disabled people, some the byproduct of malpractice, I certainly do not directly benefit from large settlements for pain and suffering, but am well aware of the costs incurred to modify homes, modify vehicles, and modify almost everything in daily living skills, any of which are not included and covered by insurance as pure medical costs. Also many of these disabilities do

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lead to shortened life spans, and putting a dollar amount on this again is impossible.

Therefore, in considering the "victory" in the Legislature relating to medical liability tort reform, one needs to understand that even within the public at large and the medical sector, there will continue to be winners and losers. Unfortunately, the majority of both physicians and the public do not come into regular contact and are not directly affected as psychiatrists might be and therefore, may not have the clearest vision in understanding the constant daily issues of these individuals. Certainly the public only becomes touched by these problems when either faced with individually or within their family or small community. Many of these people once affected would very quickly become converts in this battle of tort reform.

--Jeffrey B. Gorelick, MD
Wauwatosa❖

Pillowtalk

To the editor: "Health Care Reform Through Managed Care" seems to be on the minds and lips of every one of our state and national legislators these days. And, while most of us support - even lead the cheers for - reducing the tremendous burden health care cost has placed on us as individuals and on our national economy, few of us really understand all the short or long term implications of managed care. What exactly is it? What are the upsides of this system that make it such an attractive solution? And what, if any, are the downside risks of tying our national star to this type of systemic reform?

Ultimately, health care reform is about money. We want to spend less of it on taking care of sick people. And managed care is a very attractive solution in our search for the holy grail of reduced "sick care" cost. Managed care is about risk and reward and about changing incentive. In a mature managed care system (usually a successful Health Maintenance Organization or HMO) the health care providers (usually doctors and hospitals) are paid one rate per member per month (called a capitation) to take care of all the sickness care of a particular block of managed care subscribers. If that group of subscribers needs more care than the capitation will pay for, the health care providers lose money. If they need less care, the providers make money. It seems so very simple and straight forward.

It moves the risk of the insured people actually needing costly healthcare intervention from the insurance company or government program payor to the providers of the care. The insurance company and government know exactly what they will pay the providers each month for their services, regardless of the amount of services the particular insured group requires.

And the health care provider's

Continued on next page

Dr. Gruber adopted a 'wait and see' attitude about the healthcare legislation.

Continued from preceding page
incentive changes from doing more x-ray procedures, lab tests, inpatient admissions, etc. to doing less. No longer are they paid a fee for each procedure performed. Revenues are now fixed so costs are the only variable. The less procedures they do the less it will cost and the more money the health care provider will make.

So we've changed risks and changed incentives. No longer will the payors, who have little control of how much sickness care is necessary, be financially at risk for high health care utilization. And we've changed the incentive - health care providers will make money by doing less - not more.

I think all of us can see the potential problems in this type of system. First of all, how large must a provider be to comfortably take on this type of risk? And won't this type of system lead to large health care monopolies? Won't the small providers be squeezed out by predatory bidding practices by large health care providers who can absorb short term losses to gain long term control?

Secondly, who will decide how the dollars are equitably divided among doctors, hospitals, etc. when volume of work is no longer the determining factor in valuing contributions?

And there are other, more basic human questions. Does the patient have any choice of doctors, hospital, etc. that treats her? How much health care is enough? At what point do we decide to stop treating when those making that decision stand to gain from not treating and lose from continuing to treat? And does a small community in a healthcare network deserve a doctor, emergency room or hospital when regardless of how busy it is and how convenient for the patient, the network does not get paid more for having care available there?

But, with all the questions and potential problems, managed care continues to grow and is rapidly becoming a very dominant force in our industry. The bottom line for the payors is that it promotes efficiency and costs less. That's why it's attracted the attention of our government in its search for a Medicare and Medicaid cost reduction solution.

That is why we will be dealing with it more and more in the future.

There are some very difficult questions to answer and problems to solve in a totally managed care environment. But the potential for savings is too great to be ignored.

--Glen Grady, Administrator,
Neillsville ❖

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AIR FORCE

Soundings

On becoming a doctor: lessons from life's unlikely teachers

A PRETTY COOL THING happened to me recently: I received a diploma from medical school. Hand and glove with that diploma comes the presumption that I learned something during the last four years, and it's true. I learned countless facts from books. lectures and labs, but the kind of learning that really shaped my ideas about the doctor I want to be is a bit harder to describe.

I learned from every physician with whom I interacted at medical school--some of them were truly inspirational. I have tried to take the unique qualities I admired in each of them and integrate them into my own developing style.

Patients have also been incredibly powerful teachers. They gave me opportunities to share, feel and witness their lives. Some of them experienced minor inconveniences on my behalf. I owe them all my sincerest gratitude.

However, I think I am most grateful for a teacher who opened my eyes to a completely new realm of learning. This unlikely teacher was a homeless man named Kevin.

I was in New York City working in shelters for homeless mothers and their children. As I walked home up a rainy 5th Avenue, my solitude was invaded, "Spare change?" My patented response to such requests was to make eye contact and simply say "no." I broke my newly-acquired Manhattan speed-stride to let a woman in a luxurious fur pass, looked in the direction of the voice, and met the eyes of a man hunched over a milk crate. "No," I said. But something about this man saddened me. "I'm sorry," I added and quickened my pace.

From over my shoulder came the colorful proposition of marriage and a promise to become an honest man. Surprised, and somewhat impressed with his creativity, I looked behind me to see his eyes already cast downward into his empty cup. I was struck by how quickly he had given up on me, and I turned around.

"I'm not going to give you any money," I said. That would have been fine, but the next words out of my mouth were, "but I'll take you to dinner." At which point he looked up. We were both stunned.

He spoke first, "What?" I offered a silent apology to my safety-conscious parents and repeated, "I want to take you to dinner."

"Where?" Having just passed a McDonald's, I thought that would be a good choice, a known commodity, well-lit, good security, quick and easy, in and out, twenty minutes, max. "McDonald's puts cow eyes in their hamburgers. I don't eat that ----," he said.

"OK, where would you like to go?" I must admit that a nearby Italian-Korean cafe wouldn't have been my first choice, but he proudly led me through the smoky room to the last booth. He politely offered me the seat without the duct tape.

Soon we were talking like old friends. He told me his parents had died when he was seven and he went down south to live with his grandmother, who always made him wear white on Sundays. I told him about my parents' divorce, and how it led to the addition of stepparents and wonderful new brothers and a sister. He told me stories from the Bible; I told him stories about raising chickens. He told me someday he wants to buy an abandoned building and create affordable housing. I told him someday I want to be a summer camp director, but it looks like I'm going to be a doctor for awhile first.

He took another shot at the marriage proposal idea and tried to impress me with his manners. He explained that when he is with a woman, he always walks on the street side of the sidewalk and at night he always sleeps near the door with the gun under his side of the bed. He gracefully accepted that I was happy in my current relationship, and asked me if I had any friends. I quickly flipped through all the people I'd met in New York, and I began to think about the single mothers in the shelters.

And then it hit me. Kevin, with his eight children by five different women, with his intermittent problems with alcohol and depression, could easily be the father of any of the functionally fatherless children that I'd been seeing in the homeless shelters. It was disturbing to think that the fathers of these children could be as genuine and as kind as Kevin. I no longer had a villain in my simplistic equation of irresponsible dad plus unskilled mom equals kids without a home. I now had a new victim.

I was overwhelmed by the implications of my accidental discovery. I looked at my watch and realized that three hours had passed. I was late for the only-in-New York 10 p.m. dance class.

As I put on my coat, I realized he was still shivering. I asked him where he was going to sleep. He ex-

Continued on next page

Joeli Hettler, MD, recently graduated from the University of Wisconsin Medical School and is now a resident in pediatrics at Strong Memorial Hospital, University of Rochester, New York. This is the speech she presented at graduation.

plained that although the subway was bumpy and loud, he preferred sleeping there when he could get a token, because more than anything he hated to be cold.

I think he understood that I couldn't leave him with a way to contact me, but he quickly offered a way for me to find him. He'd be working the same corner, at 5th and 9th. He promised to put aside enough of his daily change intake to be able to pay for our next meal. I gave him a subway token, and we said a warm but awkward good-bye.

That night I thought of Kevin, warm but never really able to sleep on the rattling, lurching "3-train" that he claimed offered the most continuous ride with the least amount of hassling from conductors. Every night after that, when I was in bed, the brownstone rumbled as the 3-train tunneled beneath it. I'd think of Kevin. I'd wonder if he'd saved enough that day to be warm that night.

I still think of Kevin. I think of how I was never brave enough to go anywhere near 5th and 9th after that night. I think about how through one conversation he has changed the way I interact with patients.

He taught me that even in the purest search to understand patients as people, we can never truly know the other side. We need to let patients tell us about their lives, but be humbled with the knowledge that we only know what they tell us, and that their lives are inevitably richer and more complex than can be conveyed in any hospital or clinic setting.

More importantly, meeting Kevin so unexpectedly has sharpened my awareness of the realm of possible learning sources. I don't even need to be ready for them, I just need to learn to recognize less traditional teachable moments, and not turn away. It's easy to be afraid of what I don't understand. But I'm more afraid of not understanding. I can't help someone that I don't understand.

So, looking back over the last four years, I know I have learned many things, but more importantly, my eyes have been opened to a process of learning. Although I'll continue to learn from books, patients and other physicians, it's life's unlikely teachers that will help me best to understand. And if I understand, I might be able to make a difference.

–Joeli Hettler, MD
Rochester, NY❖

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Screening for risk of malnutrition in Wisconsin's elderly

Laura I. Vailas, MS, and Susan A. Nitzke, PhD, Madison

In older adults, nutritional status is related to chronic disease risk, ability to maintain independent lifestyles, and rate and duration of hospitalizations. Significant numbers of American elders are either malnourished or at risk of malnutrition. Data from a recent survey of 21,000 Wisconsin participants in home-delivered or congregate meals 60 years of age and older indicated that in this group, over one fourth were at high risk for malnutrition. The Nutrition Screening Initiative, a collaborative effort of the American Academy of Family Physicians, the American Dietetic Association, and the National Council on the Aging, has identified risk factors for malnutrition in the elderly and is promoting systematic nutrition risk screening and intervention within the health care system. Risk factors for malnutrition in older adults, screening techniques available to medical practices, and resources for intervention are described in this paper.*Wis Med J.1995;94(9):495-499.*

WISCONSIN, like the rest of the United States, is experiencing unprecedented growth in the number and proportion of its older citizens. According to the Wisconsin Bureau on Aging, the population group aged 65 and older increased by over 87,000 persons between 1980 and 1990. This represented nearly half of the total net gain in the state's population during that time. The group aged 85 and older has grown most rapidly, having more than tripled from 22,656 in 1960 to 74,293 in 1990.

If projections made in 1990 are correct, Wisconsin currently has 84,800 residents aged 85 and older.[1] Persons 65 and older make up 13.4% of Wisconsin's population, compared to a national average of 12.7%. Of these, 9.1% live in poverty, compared to 12.8% nationwide.[2] By the year 2030, adults 65 and older are expected to exceed 20% of the US population.[3]

The need for long-term care rises exponentially in later years. As we grapple with health-care cost control issues, the economics of the "graying of America" are just beginning to be appreciated. Interventions designed to maintain independence and decrease or delay the need for extended care in this population must be pursued. Financial considerations aside, our goals as health professionals include enhancing and maintaining quality of life and striving to prolong functionally independent lifestyles.

Nutritional status is a factor conceded by all to be important, but often overlooked in the greater scheme of patient care. In the elderly, nutritional status is related to risk for chronic disease, rate and duration of hospitalizations, and maintenance of independent lifestyles.[4,5]

Recent studies have contributed to our understanding of links between nutritional status and independence, and factors related to risk of poor nutritional status. Research on free-living New England elders found that nearly 30% consumed diets inadequate (defined as intakes of less than 75% of the recommended dietary allowances) in three or more of five key nutrients: protein, calcium, thiamin, and vitamins A and C. One fifth of the subjects consumed inadequate amounts of protein, and 16% were found to be underweight. Inadequate nutrient intake was associated with lower educational attainment and poor dental health, among other factors.[6]

Mowe' et al documented undernutrition in over half of older adults admitted to a hospital and found that factors such as inability to buy and prepare food, difficulty chewing, and reduced appetite increased risk for hospitalization.[5] In a nursing home population, weight loss of five pounds or more in a 6-month

Vailas and Nitzke are registered dietitians with the Department of Nutritional Sciences at the University of Wisconsin-Madison. Reprint requests to: Laura I. Vailas, University of Wisconsin-Madison, Department of Nutritional Sciences, 1415 Linden Dr, Madison, WI 53706.
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period was noted in 20% of subjects. In almost all cases, a single cause for weight loss could be identified, with depression found to be the most common cause. Medication-related problems and swallowing disorders were prominent among other contributing factors.[7]

Nutrition screening and intervention

The 1988 Surgeon General's Workshop on Health Promotion and Aging and the US Department of Health and Human Services Report *Healthy People 2000* recommended intensified nutrition screening in older adults. The Nutrition Screening Initiative (NSI) was established in response to this. The NSI is a project of the American Academy of Family Physicians, the American Dietetic Association, and the National Council on the Aging, and is advised and supported by a multidisciplinary blue-ribbon advisory committee representing more than 30 national health-care and aging organizations. Its purpose is to increase awareness of the need for nutrition screening and better nutrition care in the health care system.[8]

The NSI has sponsored consensus development conferences and research on nutrition and the aged, and has coordinated collaboration among nutrition and aging experts' development of empirically based materials and documents regarding nutrition needs of the elderly. Included among these are nutrition screening instruments, assessment and intervention protocols, algorithms, and monographs for use by health care and social service communities.

In the interest of clarity and consistency, the NSI has defined terms related to the documentation and treatments of poor nutritional status (Table 1), and has differentiated between major and minor indicators of poor nutritional status (Table 2).

Screening for nutritional risk

A simple yet valuable nutritional risk screening instrument developed by the NSI is the Determine Your Nutritional Health Checklist (Determine Checklist). Its name is a mne-

Table 1.—Definition and explanation of terms used by the Nutrition Screening Initiative

Poor nutritional status	Includes not only deficiency, dehydration, undernutrition and nutritional imbalances, but obesity and excesses such as alcohol abuse. Also includes inappropriate dietary intakes for conditions with nutritional implications, and presence of underlying physical or mental illness with treatable nutritional implications. Encompasses evidence that nutritional status is deteriorating over time.
Risk factors for poor nutritional status	Characteristics associated with increased likelihood of poor nutritional status. Examples are presence of acute or chronic diseases, inadequate or inappropriate food intake, poverty, dependency and disability.
Indicators of poor nutritional status	Generally quantitative; provide evidence that poor nutritional status is present. Include dietary, clinical, anthropometric and biochemical measures. Changes in indicators over time are particularly important. Major and minor indicators are listed in Table 2.
Nutrition screening	The process of identifying characteristics known to be associated with dietary or nutritional problems. Purpose is to differentiate individuals at high risk for nutritional problems, or who have poor nutritional status, from those at low nutritional risk.
Nutrition assessment	The measurement of indicators of dietary or nutrition-related factors to identify the presence, nature, and extent of impaired nutritional status of any type. Also, obtaining the information needed for intervention, planning and improvement of nutritional care.
Nutrition intervention	Action taken to decrease the risk of, or to treat poor nutritional status.
Nutrition education	The imparting of information about foods and nutrients, diets, lifestyle factors, community nutrition resources and services to people to improve nutritional status.
Nutrition counseling	The provision of individualized guidance on appropriate foods or nutrient intakes for those with special needs, taking into consideration health, cultural, socioeconomic, functional and psychologic factors.
Nutrition support	The alteration of usual food intake by route of administration, modification of nutrient content, nutrient density or food consistency. Always includes nutrition counseling; often includes use of medical nutritional supplements which may be orally administered, and provision of enteral or parenteral nutrition. Individuals who may benefit from nutrition support are those who cannot, should not, or will not eat a nutritionally adequate diet.

Adapted from *Incorporating Nutrition Screening and Interventions into Medical Practice*, The Nutrition Screening Initiative, Washington, DC, 1994; pp 3-4.

monic for the warning signs for risk of malnutrition listed in Table 3.

Shown in the figure, the Determine Checklist facilitates a rapid estimate of nutritional risk status by care providers or older adults themselves. Designed to be self-administered, it consists of 10 statements, each describing a risk factor or indicator. Each risk statement is assigned a score weighted according to the degree of risk conferred by a positive response. Respondents circle the score in the "yes" column if a statement is true for them, and total their points for an overall score of 0 to 21. A score of 0-2 is considered good, and a recheck in six months is recommended. Moderate nutritional risk is indicated by a score of 3-5.

Those with moderate risk scores are advised to see what they can do to improve their eating habits and lifestyle and recheck in three months. The appropriate recommendation for individuals with high-risk scores (6-21) is to seek further guidance from a physician, dietitian, or other qualified health or social service professional.

The Determine Checklist was developed as an educational tool to raise public and professional consciousness, with sufficient reliability for identifying potential increased nutritional risk.[9] Because of its simplicity, reliability, and educational value, it is well-suited for environments such as medical offices or clinic waiting areas, pharmacies, community meals sites, fitness centers, and health fairs.

Assessing nutritional risk in Wisconsin elders

The Wisconsin Bureau on Aging and the University of Wisconsin Extension used the Determine Checklist to screen nearly 21,000 participants in congregate and home-delivered meal programs in 74 counties and tribes throughout the state.[10] In this sample of meal program participants, 27% were at high nutritional risk, 32% were at moderate risk, and 40% were at low nutritional risk. In general, degree of nutritional risk was greater for those receiving home-delivered meals, with 83% at either high or moderate nutritional risk.

This is not surprising, since an important reason for receiving home-delivered meals is inability to procure and prepare food. Further, home-delivered meal patrons tend to have several other risk factors, including chronic illness, social isolation, low income, and use of multiple medications. In some circumstances, the home-delivered meal may be the only full meal an individual receives on a typical day.

The most frequently cited risk factors/indicators common to both home-delivered and congregate subgroups were: eating alone most of the time; taking more than three over-the-counter or prescription drugs; having a condition requiring diet modification; and consuming few fruits, vegetables and milk products.

Additionally, 66% of the home-delivered meal subjects indicated an inability to shop for food, cook, or feed themselves. It should be pointed out that subjects in this sample participated in nutritional programs designed to reduce risk of malnutrition. Consequently, these data may not be representative of

Table 3.—Warning signs for nutritional risk in older adults.

Disease
Eating poorly
Tooth loss/mouth pain
Economic hardship
Reduced social contact
Multiple medicines
Involuntary weight loss/gain
Needs assistance in self-care
Elder years above 80

Table 2.—Indicators of poor nutritional status

Minor indicators	Major indicators
Alcoholism	Significant weight loss over time
Cognitive impairment	Significantly low or high weight for height
Chronic renal insufficiency	Serum albumin <3.5 g/dL
Multiple concurrent medications	Significant change in functional status
Malabsorption syndromes	Inappropriate food intake
Anorexia, early satiety, nausea, dysphagia	Mid-arm muscle circumference <10th percentile
Change in bowel habit	Triceps skinfold <10th percentile or >95th percentile
Fatigue, apathy, memory loss, and new-onset falling	Selected nutrition-related disorders
Cheilosis, or angular stomatitis	Osteoporosis
Glossitis	Osteomalacia
Dehydration	Folate deficiency
Poor oral/dental status	B12 deficiency
Poorly healing wounds	
Loss of subcutaneous fat or muscle mass	
Fluid retention	
Reduced serum iron, folate, ascorbic acid, or zinc	

Adapted from *Incorporating Nutrition Screening and Interventions into Medical Practice*, The Nutrition Screening Initiative, Washington, DC, 1994; p. 19.

The Warning Signs of poor nutritional health are often overlooked. Use this checklist to find out if you or someone you know is at nutritional risk.

DETERMINE YOUR NUTRITIONAL HEALTH

Read the statements below. Circle the number in the yes column for those that apply to you or someone you know. For each yes answer, score the number in the box. Total your nutritional score.

	YES
I have an illness or condition that made me change the kind and/or amount of food I eat.	2
I eat fewer than 2 meals per day.	3
I eat few fruits or vegetables, or milk products.	2
I have 3 or more drinks of beer, liquor or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take 3 or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2
I am not always physically able to shop, cook and/or feed myself.	2
TOTAL	

Total Your Nutritional Score. If it's -

0-2 **Good!** Recheck your nutritional score in 6 months.

3-5 **You are at moderate nutritional risk.** See what can be done to improve your eating habits and lifestyle. Your office on aging, senior nutrition program, senior citizens center or health department can help. Recheck your nutritional score in 3 months.

6 or more **You are at high nutritional risk.** Bring this checklist the next time you see your doctor, dietitian or other qualified health or social service professional. Talk with them about any problems you may have. Ask for help to improve your nutritional health.

These materials developed and distributed by the Nutrition Screening Initiative, a project of:

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THE AMERICAN DIETETIC ASSOCIATION

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Remember that warning signs suggest risk, but do not represent diagnosis of any condition. To learn more about the Warning Signs of poor nutritional health see opposite column.

The Nutrition Checklist is based on the Warning Signs described below. Use the word DETERMINE to remind you of the Warning Signs.

DISEASE

Any disease, illness or chronic condition which causes you to change the way you eat, or makes it hard for you to eat, puts your nutritional health at risk. Four out of five adults have chronic diseases that are affected by diet. Confusion or memory loss that keeps getting worse is estimated to affect one out of five or more of older adults. This can make it hard to remember what, when or if you've eaten. Feeling sad or depressed, which happens to about one in eight older adults, can cause big changes in appetite, digestion, energy level, weight and well-being.

EATING POORLY

Eating too little and eating too much both lead to poor health. Eating the same foods day after day or not eating fruit, vegetables, and milk products daily will also cause poor nutritional health. One in five adults skip meals daily. Only 13% of adults eat the minimum amount of fruit and vegetables needed. One in four older adults drink too much alcohol. Many health problems become worse if you drink more than one or two alcoholic beverages per day.

TOOTH LOSS/MOUTH PAIN

A healthy mouth, teeth and gums are needed to eat. Missing, loose or rotten teeth or dentures which don't fit well or cause mouth sores make it hard to eat.

ECONOMIC HARDSHIP

As many as 40% of older Americans have incomes of less than $6,000 per year. Having less – or choosing to spend less – than $25-30 per week for food makes it very hard to get the foods you need to stay healthy.

REDUCED SOCIAL CONTACT

One-third of all older people live alone. Being with people daily has a positive effect on morale, well-being and eating.

MULTIPLE MEDICINES

Many older Americans must take medicines for health problems. Almost half of older Americans take multiple medicines daily. Growing old may change the way we respond to drugs. The more medicines you take, the greater the chance for side effects such as increased or decreased appetite, change in taste, constipation, weakness, drowsiness, diarrhea, nausea, and others. Vitamins or minerals when taken in large doses act like drugs and can cause harm. Alert your doctor to everything you take.

INVOLUNTARY WEIGHT LOSS/GAIN

Losing or gaining a lot of weight when you are not trying to do so is an important warning sign that must not be ignored. Being overweight or underweight also increases your chance of poor health.

NEEDS ASSISTANCE IN SELF CARE

Although most older people are able to eat, one of every five have trouble walking, shopping, buying and cooking food, especially as they get older.

ELDER YEARS ABOVE AGE 80

Most older people lead full and productive lives. But as age increases, risk of frailty and health problems increase. Checking your nutritional health regularly makes good sense.

The Nutrition Screening Initiative, 1010 Wisconsin Avenue, NW, Suite 800, Washington, DC 20007

The Nutrition Screening Initiative is funded in part by a grant from Ross Laboratories, a division of Abbott Laboratories

Fig—Determine checklist.

Wisconsin elderly overall. Since the demand for adult meal programs exceeds existing resources in many locations, the total numbers of Wisconsin elders at potentially high nutritional risk is not known.

The Level 1 and Level 2 Screens

Individuals who are found to be at high or moderate risk by the Determine Checklist should be evaluated further using the Level 1 or Level 2 Screens, both of which should be administered by trained personnel. The Level 1 Screen is intended for administration by persons such as meal site workers, nursing or health aides, and day care personnel trained by nutrition, health or social service professionals. It includes measurements of height and weight, and a review of eating habits, living environment and functional status. Examples of appropriate action following the Level 1 Screen include referral to the individual's primary health-care provider if sudden weight loss or gain is detected, referral to a dietitian for those having difficulty consuming an adequate diet, and referral to a social service agency for those who do not have sufficient food. It should be emphasized that pharmacists, dentists, mental health experts, and social service professionals are necessary components of a comprehensive health care network. As such, they constitute both sources of referrals

and resources to whom patients may be referred.

The Level 2 Screen may be administered by physicians, nurse clinicians and trained dietitians. This device provides comprehensive information regarding nutritional status and helps detect presence of major and minor indicators of malnutrition. It can be incorporated into the medical record, or adapted to complement existing medical office or clinic protocols. Because it is highly specific, its use greatly facilitates determination of appropriate interventions and referrals.

Interventions for nutritional risk

Once problems have been characterized and clearly identified, appropriate intervention can reduce risk for malnutrition and improve nutritional status. Interventions generally fall into one or more of the following categories: social services, oral health, mental health, medications use, nutrition education and counseling, and nutrition support. Appropriate professionals or agencies can assist with further evaluation and tailoring interventions to the patient's needs. For example, the offices of the State Bureau on Aging and the County Agencies on Aging are valuable resources for information on availability of congregate and home-delivered meals and other services available to older adults in Wisconsin.

Resources for medical practice

A home-study course for physicians available through the NSI is currently approved for 5 prescribed hours by the American Academy of Family Physicians. The monograph, "Incorporating Nutrition Screening and Interventions into Medical Practice," contains copy-ready masters for each of the screens described above. Additionally, it is a comprehensive source of information pertaining to assessment of nutritional risk in older adults and the most beneficial interventions. There is a particularly valuable section on identifying locally available resources for each category of intervention. This manual and other materials may be obtained by calling or writing the Nutrition Screening Initiative, 1010 Wisconsin Avenue NW, Suite 800, Washington, DC 20007; 202/625-1662.

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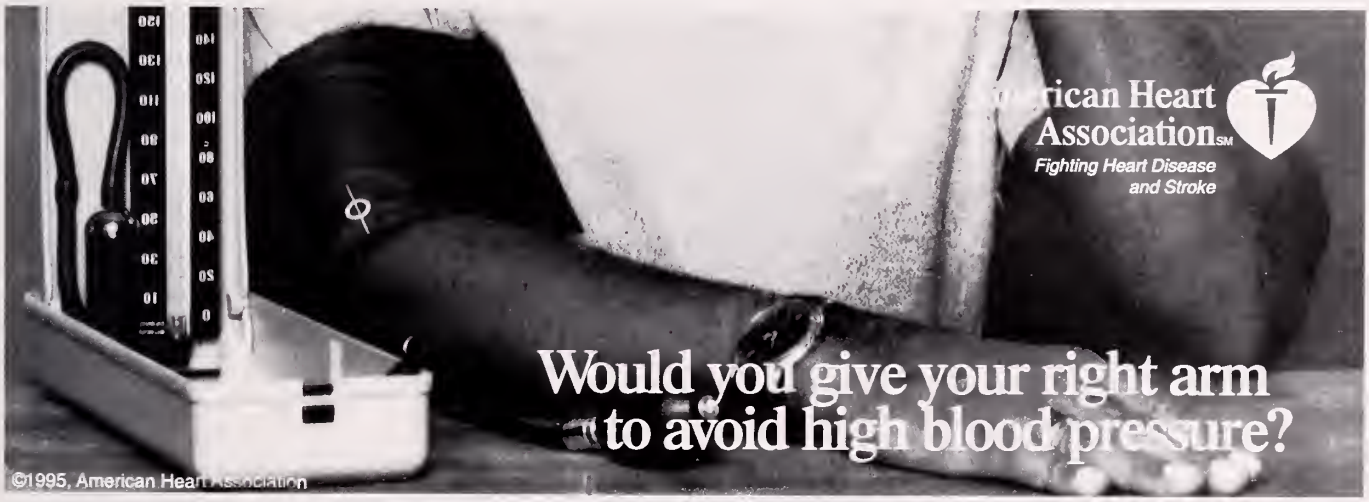

Evaluation for surgical treatment of partial epilepsy: an overview

Selim R. Benbadis, MD, Milwaukee

When a focal epilepsy proves refractory to medical therapy, surgical treatment is available and increasingly used. Most interventions consist of focal cortical resections, and by far the most common operation is a temporal lobectomy. The presurgical evaluation is complex and multidisciplinary. It includes clinical evaluation, EEG-video monitoring, neuropsychological testing, and structural as well as functional imaging. When surface EEG fails to identify the epileptogenic zone with sufficient confidence, several invasive methods are available, each with its advantages and limitations. In addition to neurophysiologic data, when there is convergence of structural imaging (MRI) and functional testing (Wada test, neuropsychological evaluation, nuclear imaging), a single focus can be identified, and a focal resection is likely to be successful. Surgery is a well-accepted and effective therapeutic modality for patients with refractory epilepsy. When surgical candidates are selected appropriately, results are excellent, especially for temporal lobe epilepsy.*Wis Med J.1995;94(9):500-504.*

THE PREVALENCE OF EPILEPSY is approximately 0.5% to 1%.[1] About 20% to 30% of patients prove resistant to medical treatment,[2] and 15% may be candidates for surgical treatment. Despite the recent emergence of epilepsy programs, the number of interventions performed is fewer than the number of potential candidates. The most commonly performed operation, which is the focus of this review, is a cortical resection of a focal epileptogenic zone, most commonly a temporal lobectomy.

The general indications for surgical treatment of epilepsy by a focal resection are: a diagnosis of a focal (partial, localization-related) epilepsy, medical intractability, debilitating seizures, and an epileptogenic zone localized in a resectable area of the brain. Epilepsy is generally considered intractable when seizures remain uncontrolled despite the maximum doses of major antiepileptic drugs (AEDs) tolerated by the particular patient. A sufficient number of AEDs must have been tried before deciding that an epilepsy is medically intractable. However, it has been shown that when one major AED fails, the chances that another one will succeed are low, and the chances of added toxicity are high,[3] so that not all AEDs need be tried.

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General principles

The presurgical evaluation for a cortical resection involves a multidisciplinary approach which includes: history, general and neurological examination, brain magnetic resonance imaging (MRI), functional imaging, neuropsychological testing including Wada testing for language and memory, and EEG-video monitoring. Neurophysiologic data are most accurate in terms of localization, but all results must be considered independently, and preferably be convergent.

Clinical data

It is during this initial phase that the diagnosis of epilepsy is made. A detailed history usually permits classification into focal (partial, localization-related) epilepsy, where seizures arise from a limited area (focus) of the brain, or generalized epilepsy, where they arise synchronously from several areas in both hemispheres. Because partial seizures are all classified as complex if there is a loss of awareness, care must be taken not to label every seizure "complex partial" on historical data alone (a common pitfall), since many nonepileptic events (and seizures that are not partial) can resemble complex partial seizures. In addition, the term complex partial

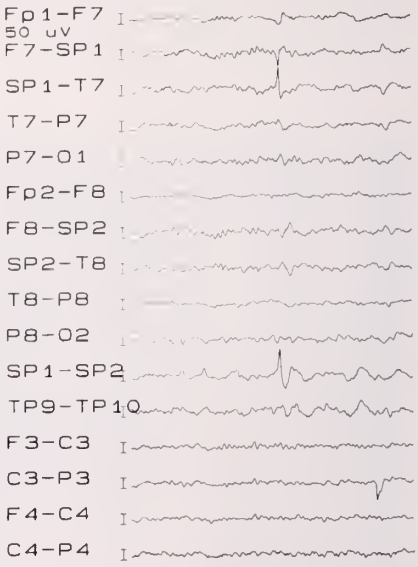

Fig 1.—Segment of interictal EEG: left temporal spike. Scale (50μV) shown at the left of tracing. Each vertical line corresponds to 1 second.

seizure (CPS) is not equivalent to temporal lobe epilepsy, since it may include a variety of seizures that have little in common except for some alteration in awareness, as pointed out by others,[4] and since CPS can arise from almost anywhere in the brain.[5,6]

The presence of an aura (initial symptom that the patient remembers) unequivocally makes the diagnosis of a focal seizure, since an aura is actually a simple partial seizure. Provided that not every premonitory symptom is interpreted as an aura (another pitfall), the nature of the aura may give crucial information about the localization of the initial discharge.[7]

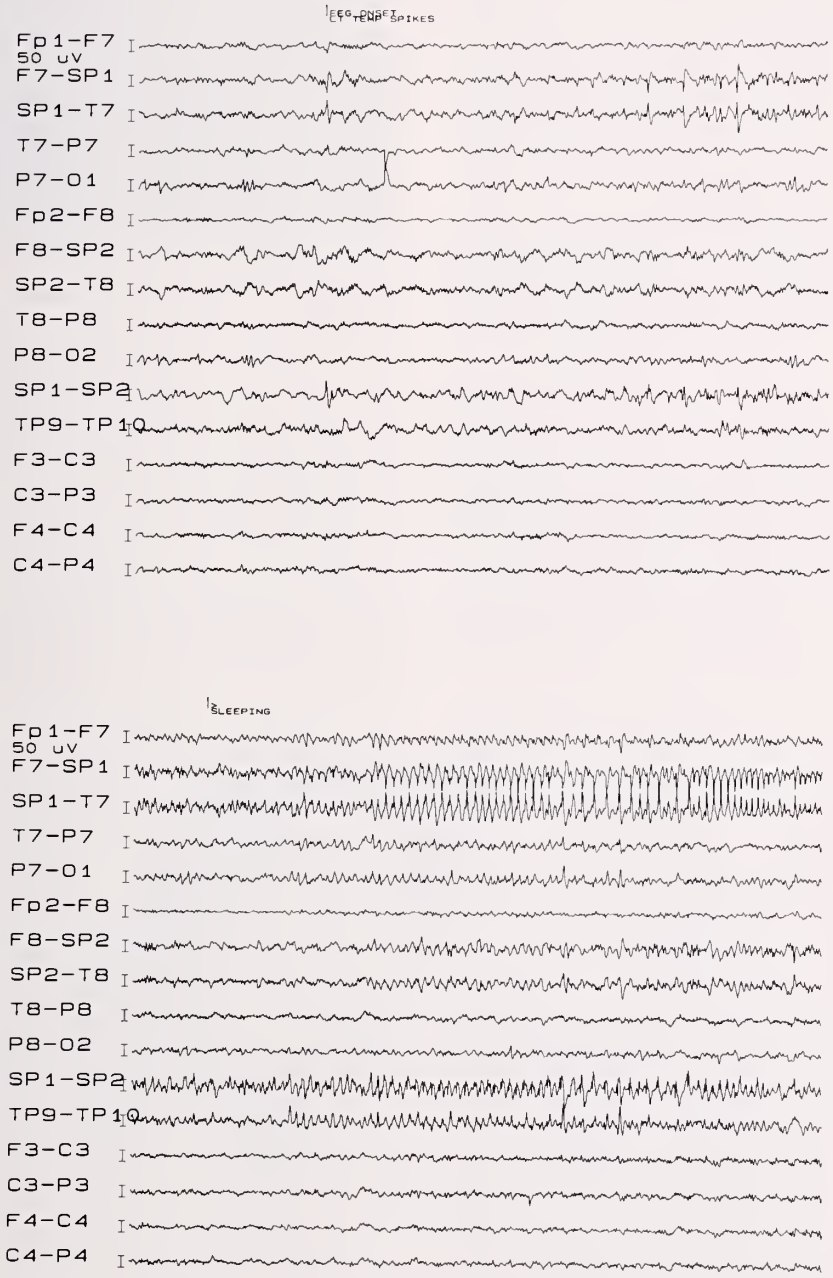

Fig 2.—Ictal EEG recording: typical electrographic seizure, with clear ictal onset in the left mesial temporal region (electrode Sp1). Scale (50μV) shown at the left of tracing. Each vertical line corresponds to 1 second.

Routine EEG

Although the initial EEG may be very useful in supporting a clinical diagnosis of epilepsy, it is never sufficient to proceed with epilepsy surgery, because it is extremely limited in terms of both time and space. A normal routine EEG never rules out epilepsy, since it is frequently normal in patients with proven epilepsy. When present, focal spikes or sharp waves provide strong supportive evidence for a focal epilepsy and its probable location.

Noninvasive EEG-video monitoring

This is the first and essential phase in all potential candidates for a surgical treatment, and in general for patients whose seizures are uncontrolled. The prolonged nature of the recording allows one not only to analyze a greater sample of interictal EEG, but also to record the actual events for which the patient sought medical attention. Monitoring can be done continuously 24 hours a day, or in an outpatient setting, and may last from a few hours to several weeks.

It is usually necessary to reduce or discontinue antiepileptic drugs, in order to obtain seizures within a reasonable time. The EEG is carefully scrutinized for interictal epileptiform abnormalities (spikes or sharp waves, Fig 1) and, most important, to analyze the seizures. Seizures must be analyzed in terms of their clinical characteristics (video) as well as electroencephalographic features (Fig 2). Careful analysis of seizure semeiology provides essential localization information. The International Classification of Epileptic Seizures (ICES)[8] is most often used, but alternative classification systems are gaining acceptance due to the shortcomings of the ICES.[9]

It is not uncommon during this

phase to find that refractory "seizures" that have been treated as epileptic for years are actually nonepileptic in origin, but psychogenic. This occurs in 10% to 20% of patients referred to an epilepsy center for intractable epilepsy.[10]

Once completed, this first phase of electro-clinical analysis can distinguish four broad groups of patients.

Unilateral temporal focus. This group represents the majority of cases for which a surgical treatment is considered. Interictal and ictal discharges are maximal in one temporal region. When all data converge toward the same temporal lobe, these patients can generally undergo a temporal lobectomy without invasive neurophysiologic studies.

Bilateral or uncertain (left or right) temporal focus. This group resembles the preceding one, except that the side of seizure onset is uncertain. This may be because epileptiform EEG abnormalities are in both temporal regions, or because EEG lateralization is inconsistent with other data such as Wada testing, functional imaging, MRI, or neuropsychological data (see below).

Depending on the specific situation, a temporal lobectomy may be considered, but in many cases invasive EEG studies will be necessary to ensure that one temporal lobe is generating the disabling seizures. This can be performed using bilateral subdural strips or intracerebral depth electrodes (see below).

Unilateral nontemporal focus. In these cases, the clinical characteristics of the seizures often suggest an extratemporal origin, despite the fact that they are often classified as "complex partial" in the ICES. It is because of the nondescript significance of this term, a serious shortcoming of the ICES, that some authors clearly distinguish between CPS "of temporal origin" and other CPS,[11] while others advocate abandoning the term altogether.[9] Epileptiform abnormalities, especially ictal, are not in the temporal region, but frontal, parietal, or occipital. If a cortical resection is considered, it is usually necessary to employ invasive EEG techniques (see below), particularly in the absence of structural MRI abnormality.

Bilateral nontemporal foci. These patients are generally not candidates for a focal resection, and typically suffer from a generalized or "multifocal" epilepsy, for which the therapeutic approach should be different.

Invasive EEG

This second phase may be essential, and differs according to the clinical circumstances. Various techniques are available.

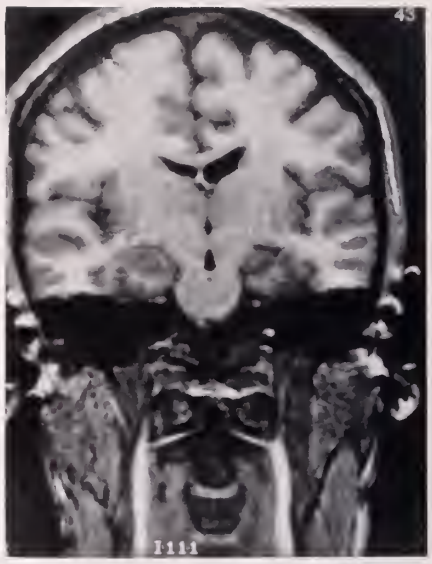

Fig 3.—Coronal MRI: left hippocampal atrophy.

Depth (intracerebral) EEG. These intracerebral electrodes are placed stereotactically by the neurosurgeon in both temporal lobes under general anesthesia. They are particularly useful when the seizures are of temporal origin, but the side is uncertain. The majority of patients whose temporal lobe seizures appear to be bilateral by scalp EEG turn out to have an exclusive or predominant side of seizure onset when studied with depth EEG, and can therefore benefit from a temporal lobectomy.[12] However, patients with bitemporal epileptiform abnormalities are a difficult subgroup for which the interpretation of confirmatory tests is more difficult.[13] The most common complication of depth electrodes is hemorrhage, which occurs in approximately 1% to 3% of cases.

Epidural and subdural electrodes. These are also placed by the neurosurgeon in the operating room. Depending on the surface to cover, they can be arranged in strips or in grids. Grids allow coverage of extensive areas of cortex, but necessitate a craniotomy, and therefore must usually be unilateral. Strips, on the other hand, can be inserted through burr holes, and can be bilateral when the side of seizure onset needs to be determined.

Subdural electrodes are more invasive then epidural ones, since they are directly on the pia mater. In addition to recordings of better quality, they allow cortical stimulation and evoked potentials for functional mapping in order to identify and spare essential cortex (primary motor or sensory, language).[14] Functional mapping by cortical stimulation can also be performed intraoperatively,[15] with the time limitations inherent to the environment.

By contrast, epidural electrodes do not allow cortical stimulation, which would be painful due to innervation of the dura, but are somewhat less invasive. They are also limited to the convexity, and cannot explore the basal temporal, orbitofrontal, or interhemispheric areas, which can only be studied with subdural electrodes. Both epidural and subdural electrodes carry a risk of infection of approximately 1% to 6%.

Other techniques. Specific situations may call for other techniques. Foramen ovale electrodes[16] are consid-

ered "semi-invasive"; they are inserted through the cheek, and are useful to study mesial and basal temporal regions. Epidural pegs are sometimes used to screen large "custom made" areas with isolated electrodes.[17]

Intracarotid amobarbital procedure (IAP) or Wada test

Introduced by Wada in 1949, this procedure tests each hemisphere separately while the other is anesthetized by intracarotid amobarbital. It is used primarily to determine which hemisphere is dominant for language, which may modify the extent of the resection. It also allows for verification that the hemisphere contralateral to a planned resection can adequately support memory, in order to prevent catastrophic memory deficits after lobectomy.[18] Finally, an asymmetric memory representation on the IAP may be an adjunctive argument for lateralization when this is difficult to ascertain.[19]

Imaging studies

An MRI of the brain is always necessary, and may show a variety of focal lesions, most commonly neoplasms, vascular malformations, or neuronal heterotopias. MRI is far more accurate than CT, and every patient with focal epilepsy should undergo an MRI.[20] When the temporal lobe is the region of interest, thin coronal cuts identify hippocampal atrophy (Fig 3) with great precision and sensitivity.[21]

Functional imaging techniques include positron emission tomography (PET, Fig 4) and single photon emission tomography (SPECT). PET[22] provides better quality, and is usually performed interictally to identify regional hypometabolism. SPECT can identify interictal hypoperfusion and is less costly, but images are of lesser quality. It also has the advantage that it can be performed ictally, when it typically reveals focal hyperperfusion.[23]

Neuropsychological testing

In some cases, these tests, especially the comparison between verbal and nonverbal components, can provide adjunctive arguments for the localization, or at least the lateralization, of the epileptogenic region.[24]

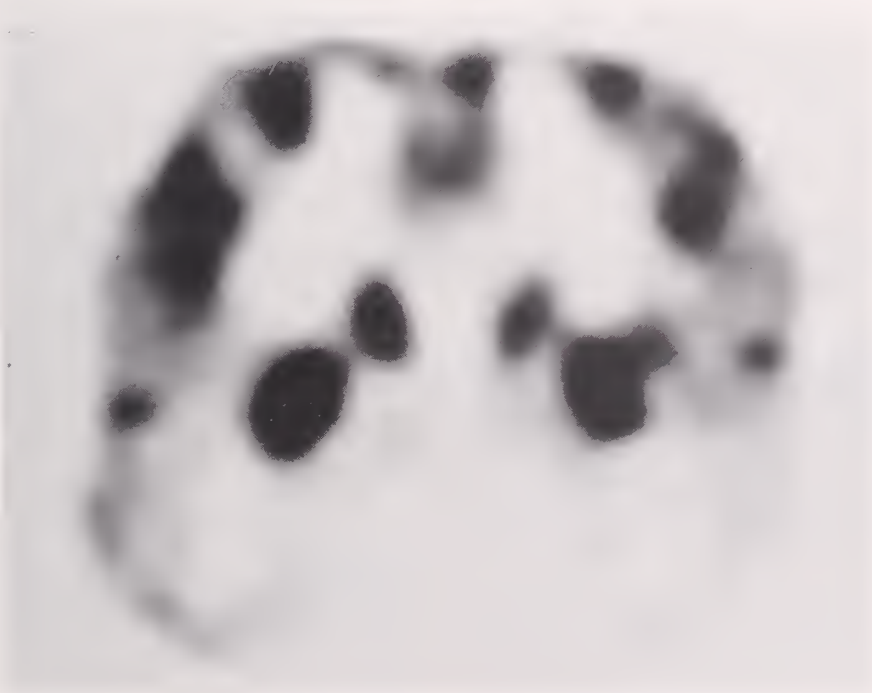

Fig 4.—PET scan: mild asymmetry with left temporal hypometabolism.

Prognosis and outcome

For the most frequent operation, temporal lobectomy, results are excellent, although highly dependent on proper selection of surgical candidates. Overall, seizures are eliminated in approximately 60% of patients, and significantly reduced in 80%.[25] Among cases of temporal lobe epilepsy, the best results are seen with mesial temporal epilepsy, typically related to a remote history of febrile convulsions. In particular, when there is MRI evidence of hippocampal atrophy which is convergent with the EEG data, surgical outcome is excellent in 97% of patients, according to recent studies.[26] Results are slightly less satisfactory in extratemporal cases, especially when there is no causal lesion.[27]

Conclusions

When epilepsy proves refractory to optimal medical therapy, a surgical treatment should be considered. Several surgical procedures are available. All necessitate an extensive and multidisciplinary evaluation. Epilepsy surgery is now a well-accepted therapeutic modality for refractory cases. When the candidates for surgery are properly selected, results are excellent, especially for temporal lobe epilepsy.

Acknowledgement

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Palliative medicine education at the Medical College of Wisconsin

David E. Weissman, MD, Milwaukee

Palliative medicine is an emerging worldwide discipline. This article describes efforts at the Medical College of Wisconsin to develop programs to enhance palliative care education and clinical care. New courses, seminars, and clinical programs have been developed with assistance from various medical school departments and affiliated hospitals. Education and clinical care activities since 1990 have included a new 6-week course for 2nd-year medical students; a hospice volunteer experience for preclinical students; clinical electives for 3rd- and 4th-year medical students; a clinical palliative care consultation service; a palliative care seminar series designed for housestaff; a nurse preceptorship program; and an allied health observership program. Palliative care activities include both the academic medical center and community health agencies. The MCW has integrated palliative care into its academic environment so that trainees at all education levels now have opportunities for didactic and clinical palliative care education.*Wis Med J.1995;94(9):505-508.*

PALLIATIVE CARE IS defined as the "active total care of patients whose disease is not responsive to curative treatment."[1] Palliative medicine is the name given to the medical specialty, now established in England, Ireland, and Australia, that has become focused on such care. Although palliative care is usually thought of as care specifically for dying patients, the concept of a *palliative approach to care*, could easily extend to any patient with an incurable disease, at any time during the disease course.

The discipline of palliative medicine includes assessment and management of physical symptoms; psychosocial and disposition problems affecting dying patients and the patient-family unit; ethical and communication issues related to end-of-life decisions; and application of specific treatment modalities such as hydration, feeding, blood products, radiotherapy, antibiotics, etc. The most common concerns in palliative medicine include pain management, assisting patients and families with end-of-life decisions, and developing end-of-life treatment plans that maximize home care, symptom control, and family support.

The concept of quality palliative care in the United States, not to mention the development of a distinct medical specialty of palliative medicine, lags far behind many European nations, Canada and Australia. Palliative medicine is a recognized medical specialty in several countries, and Canada has academic departments of palliative medicine. Canada has also developed a comprehensive medical school curriculum for palliative care, developed as a joint effort among 12 medical schools .[2-5]

Such efforts in the United States are in their infancy. The barriers to improved palliative care in the United States continue to be lack of awareness of the problems of terminally ill patients, poor reimbursement provisions for physician and nurse palliative care services, low academic interest in palliative care, and minimal funding for palliative care research and education. The lack of quality, readily available palliative care in the United States has in part been responsible for the recent public interest in legalizing physician-assisted suicide and euthanasia.

Since 1990 the Medical College of Wisconsin (MCW) has worked to develop a comprehensive Palliative

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Care Program that would integrate palliative medicine into its academic environment. This effort has included undergraduate and graduate teaching programs together with community involvement (Fig 1). This report will describe how MCW has made palliative medicine a recognizable aspect of its education and clinical care programs.

Setting

The Medical College of Wisconsin has an undergraduate medical school class of approximately 200 students per year and a graduate training program that includes 72 residency and fellowship programs with over 700 postgraduate trainees each year. There are two main teaching hospitals on the MCW campus, John L. Doyne Hospital, and the adjoining Froedert Memorial Lutheran Hospital.

Development

The concept of an interdisciplinary clinical and education program in palliative care on the MCW campus was first proposed in 1990. This idea originated after recognition by medical, nursing, and social service staff that care for dying patients was poorly coordinated and that little attention was given to symptom control. The MCW Office of Education Services, the Department of Internal Medicine, and the MCW Center for the Study of Bioethics were particularly supportive of improving palliative care education. As a first step, a new preclinical course, Palliative Medicine, was begun in 1991.[6]

In 1993 a clinical nurse specialist in palliative care was recruited to begin a clinical palliative care program that would augment medical student and housestaff training. Also in 1993, a relationship was established between the medical school, a community hospice program, and a community long-term care facility, a relationship designed to improve patient care in these programs and to enhance medical school education. The Palliative Care Program originated and continues to function within the Division of Hematology/Oncology in the Department of Internal Medicine.

Undergraduate palliative care education

Palliative medicine course. In 1991 a 6-week mandatory course for 2nd-year medical students, "Palliative Medicine," was introduced. The new course emphasized clinically relevant aspects of care such as communication skills, symptom control, and physician responsibility. This course, now in its 4th year, has been enthusiastically received by students, including requests for clinical electives in palliative medicine.[6]

An opportunity for students to work as volunteers in a community hospice program was started in 1993. Since then over 20 students have completed the required volunteer training course. In 1995 the palliative medicine course will be merged with the second-year course in bioethics to provide greater depth and continuity between these two subject areas.

Clinical Electives. A 2-week elective in palliative care for third-year students was started in 1992 and a 4-week elective for 4th-year students was started in 1993. The curriculum includes inpatient and outpatient consultations with the Palliative Care Service (see figure), clinical experience at the MCW Pain Management Center and home visits with staff of a home hospice program. Students complete a pre- and posttest and receive an extensive reading syllabus.

Palliative Care Service

In 1993 the Palliative Care Consultation Service (PCS), a section within the Division of Hematology/Oncology, began patient care services. Clinical care is coordinated by the author, a medical oncologist, and a clinical nurse specialist. Clinical activities include (1) providing assistance with symptom control, particularly pain management; (2) assisting patient, families, and the medical team in end-of-life decision-making; and (3) serving as a resource for coordination of discharge planning.

Since April 1993 the PCS has seen over 400 patients, averaging three to five new inpatient consultations per week.[7] Patients with any terminal illness are appropriate for a PCS consultation but the most common diagnoses have been cancer and AIDS. Outpatient palliative care consultations are conducted in the hematology/oncology clinic.

The PCS is the focal point for all clinical education activities. This includes observing trainees conduct patient interviews and symptom assessments, teaching trainees how to establish a prognosis so that appropriate discharge plans can be established, teaching principles of pain management, including use of drug and nondrug therapies, and finally, teaching how bioethical principles are applied to end-of-life decision-making.

Other Education Programs

Palliative Care Seminar Series. In 1993 the Palliative Care Seminar Series (now the Shari Croen Memorial Palliative Care Conference) was started. This is a monthly program for all interested health professionals on the MCW campus. The educational content is at the level of internal medicine housestaff. Programs are designed to be interactive, emphasizing acquisition of essential knowledge and skills.

Topics for the 1993/94 year included withdrawal of feeding and hydration, communication skills, psychological issues for HIV patients, assessment and management of pain, nausea, delirium, and dyspnea. Each conference averages over 50 participants, including residents, nurses, medical and nursing students, social workers, and clergy.

Nurse Preceptorship. A formal course has been designed whereby community nurses spend 3 to 5 days working as a member of the Palliative Care Service. The course includes a precourse knowledge test, assigned readings, and the opportunity to perform new patient and follow-up assessments on both inpatients and outpatients.

Nurses have the option of spending time in the outpatient Pain Management Center (Department of Anesthesiology) or making home visits with a home hospice program. Each nurse receives a large binder of resource material. The course has been approved for continuing education credit by the Wisconsin Nurses Association. Since April 1993, 37 nurses have completed the course.

Palliative Medicine Observership. Nonphysician health professionals have the opportunity to work for 2 to 4 weeks with the Palliative Care Service as observers. Since 1993 we have hosted senior nursing students, pharmacy residents, bioethics graduate students, and nurses working toward advanced degrees.

Other Community Resources. The PCS has established strong links with several community agencies including home and inpatient hospice programs and chronic care facilities that emphasize palliative care. These agencies have allowed us to place medical and allied health students with them for short-term educational experiences. In turn, these agencies have their staff attend the Palliative Care Seminar Series and the PCS is available for consultation regarding difficult patient management issues.

Fig.--MCW Palliative Care Program.

Medical School
2nd-year course "Palliative Medicine"
Hospice Volunteer Program
3rd-, 4th-year clinical electives

Hospitals - Housestaff Program
Palliative Care Service
Seminar Series

Community Agencies
Nurse Preceptorship

Allied Health Schools
Observership Program

Discussion

Prior to the 1960s there was little attention in US medical schools concerning the care of dying patients. With the growth of the modern hospice movement, issues related to death and dying have gradually been incorporated into the curriculum of most medical schools.[8] However, this often represents only preclinical lectures and occasionally a dedicated preclinical course that may or may not include a clinical experience. Even rarer are educational programs in the medical school clinical or housestaff training years that specifically address issues of dying patients.

The growth and development of the MCW Palliative Care Program was in large part stimulated by the recognition that dying patients were receiving suboptimal care. Identified deficiencies included poor symptom control, poor communication between physicians and their patients regarding end-of-life decisions, and poor discharge planning leading to unnecessary hospitalizations and fragmented care.

Once identified, several principles were established that have guided subsequent education initiatives. These include: (1) physician education must be longitudinal, starting in the preclinical years and extending throughout housestaff training; (2) educational efforts must include nurses, pharmacists and other health professionals; (3) improved communication skills are vital to all aspects of palliative care; and (4) educational activities must include recognition of attitude barriers along with acquisition of both knowledge and skills.

The importance of having a clinical palliative care program (PCS) that directly interacts with patients, families and medical trainees cannot be overemphasized. It is fine to teach palliative care principles to second-year medical students, or give a lecture series to housestaff, but without a clinical environment which reinforces these concepts, such teaching is likely to have little to no impact on subsequent practice.

The presence of the PCS has stimulated greater awareness among medicine, nursing, social service, and pharmacy personnel of the problems and challenges of caring for the dying. New pain assessment and quality assurance programs, based within individual service departments or ward units, have been started as a result of PCS activities.

The Palliative Care Program at MCW represents an attempt to integrate palliative care education and clinical activities across all facets of the academic environment: preclinical and clinical medical student education, housestaff education, and allied health training. Palliative care education at MCW has helped bring together the academic campus and community health agencies, agencies that offer a wealth of teaching opportunities for both medical and nonmedical health professionals.

Palliative care, an unknown term 5 years ago, is now a readily understood concept within the medical center. Although some of our pro-

grams are designed to meet particular MCW needs, the type of educational program outlined in this report could serve as a model for other medical schools.

In 1990 the World Health Organization recommended that all member nations establish "national policies and programs for cancer pain and palliative care" and that "governments should assure that health-care workers are adequately trained in palliative care."[1] To date, the United States has failed to follow the WHO recommendations with the result that palliative care education and clinical services are largely neglected by mainstream medicine.

Although good palliative care will neither eliminate all suffering nor obviate all patient desires for physician-assisted suicide, the provision of quality, affordable, and readily available palliative care services to dying and seriously ill patients should be viewed as a necessary and essential aspect of health care in the Unites States.

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The debate over physician-assisted suicide

C. L Junkerman, MD, Milwaukee

Physician-assisted suicide: Is it crime against humanity or is it a compassionate response to the suffering of a fellow human being? This is a current problem for the medical profession, ethicists and for the American public. This article will explore some of the historical perspectives, competing arguments, and recent initiatives; it will also suggest some possible physician responses.

Historical perspectives

The conflict of opinion on physician-assisted suicide has gone on through the ages. In classical Greece, there was a practical recognition of the limitations of medicine—treating incurable cases could do nothing more than prolong suffering and engender false hopes.

Hippocrates is quoted as follows: "The duty of medicine in general terms is to do away with the sufferings of the sick, to lessen the violence of their diseases and to refuse to treat those who are over-mastered by their diseases, realizing that in such cases medicine is powerless."[1]

But, in contrast to these statements attributed to Hippocrates himself, the Hippocratic Oath says: " I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect."[2]

This inconsistency was resolved by the discovery that the oath actually came from a small sect, the Pythagoreans, who flourished about 100 years after the death of Hippocrates. They believed that life is a stewardship conferred by the gods and is not mans' to give or take--a religious argument, which finds other expressions in the oath (namely, abortion).

Christian teachings found this compatible theologically and made authoritative use of it by appending Hippocrates' name, although it was far from Greek and Roman contemporaneous practice. "Throughout antiquity many people preferred voluntary death to endless agony. This form of "euthanasia" was an everyday reality ...(and) many physicians actually gave their patients the poisons for which they had asked."[3]

Socrates, whose suicide was politically mandated and not physician assisted, had maintained, "I should only make myself ridiculous in my own eyes if I clung to life and hugged it when it had no more to offer!"[1]

With the influx of Greek thought into Rome, the tolerance toward suicide continued in the Roman world. "The pervasive influence of stoic ideals further attenuated a physician's obligation to prolong life in the face of debilitating illness ...Roman literature testifies of increasingly permissive attitudes toward suicide ...Once the decision was thoughtfully made, poisons were a common means of peaceful escape ... there is little doubt that the physician's toxicological knowledge facilitated this endeavor."[1]

> "I should only make myself ridiculous in my own eyes if I clung to life and hugged it when it had no more to offer!"
> ...Socrates

Sir Thomas More addressed the issue in his "Utopia" published in 1516 thus: ".... if a disease is not only incurable but also distressing and agonizing without cessation, then the priests and public officials exhort the man .... to free himself from this bitter life ... "[3] "When the sick have been persuaded of this, they end their lives willingly, either by starvation or drugs that dissolve their lives without any sensation of death. Still, the Utopians do not do away with anyone without his permission, nor lessen any of their duties to him."[4]

Even two of the 17th and 18th century philosophers who so greatly influenced Jefferson and the founding fathers did not agree. John Locke claimed that there was an inalienable right to life, and that no one, "not even the self" had the privilege of denying this fundamental right.

But David Hume felt otherwise: "that suicide may often be consistent with self interest and with our duty to ourselves, no one can question, who allows that age, sickness, or misfortune may render life a burden, and make it worse even than annihilation."[4]

Despite the ancient tolerance of physician-assisted suicide, and the continuing debates through the ages, there has been a general proscription against this practice in British and American medicine for several hundred years.

Arguments and counter arguments against assisted suicide

1. Assisted suicide is illegal

Suicide is not illegal, but assisting a suicide is and can be prosecuted in Wisconsin (Wl statute 940.12). All states now have some sort of legal prohibition against both euthanasia and assisted suicide. (Michigan's statute is currently under legal challenge and the passage of ballot measure 16 in Oregon may change this unanimity).

2. Assisted suicide is unethical

1. AMA policy states: "The intentional termination of the life of one human being by another is contrary to public policy, medical tradition, and the most fundamental measures of human value and worth."[5]

2. The American College of Physicians Ethics Manual says, "Although a patient may refuse a medical intervention and the physician may comply with this refusal, the physician must never intentionally and directly cause death or assist a patient to commit suicide."[6]

Counter: A strong argument for assisted suicide is compassion; to help a patient end his or her unrelenting, untreatable suffering. Erich Loewy says that instead of framing the question as "killing" or "relieving suffering," it should be thought of as "harming" or "preventing harm." For example, physician participation in capital punishment is unethical and reprehensible because the person does not desire to die and thus is harmed.

Physician participation in the suicide of a patient who is hopelessly suffering and requests aid is not harming but is carrying out the caring function of the good physician. Refusing to help may itself be harming and thus an unethical act.[7]

3. The medical profession is committed to healing and the preservation of life.

Some physicians consider the goal of medicine to be solely a commitment to healing and the preservation of life, and will argue that treatment designed to bring on death does not heal and is, therefore, inconsistent with the physician's role in the doctor-patient relationship.

Counter: Healing is not the only goal in medicine, nor is the simple preservation of biological life—especially a mindless preservation of life when the quality of that life has been so diminished that the person concerned does not wish to have it prolonged. Equally important and legitimate goals of medicine are relief of pain and suffering, amelioration of disability, provision of care and avoidance of undue harm to patients.

Brody casts the argument in terms of a "good" or "bad" death. A physician is successful when the patient has, if possible, lived a natural life span and is "... allowed to die in a setting of his or her own choosing, as free as possible from pain and other burdensome symptoms ...".

"In sum, medicine produces a good death when it uses life prolonging interventions as long as they produce a reasonable quality of life and a reasonable level of function (defined in terms of the patient's own life goals) ...". But in a few cases, patients will face a bad death despite all medical efforts and physicians must confront the failure of medical intervention to arrange a good death. In these few cases, it would be morally defensible for the physician to assist a suicide as a "reasonably compassionate outcome for the suffering patient who voluntarily requests assistance."[8]

"There is little difference between the physician's role as an accomplice to death or as an agent of death...."

4. If assisted suicide were an option would physicians take the easy way out and not try so hard to relieve symptoms and to give patients other support?

This question raises a doubt about the integrity of the medical profession and the judgment of physicians.

Counter: True adherence to professional values and judgments would keep assisted suicide in perspective as a very rare option to be exercised only in unusual circumstances, and at the repeated request of the patient. Patients trust their physicians to make many other decisions that may have life and death implications; the rare instances of a decision, initiated by the patient, about assisted suicide should be no different.

5. There is no difference between assisted suicide and euthanasia.

Leon Kass states that,"There is little difference between the physician's role as an accomplice to death or as an agent of death. Assisting in a patient's death is as much in violation of the venerable proscription against euthanasia as were the physician to do it himself."[9]

Counter: Most ethicists would agree that there is a significant difference which derives from the agency; in euthanasia the physician is the direct and immediate cause of the death of the patient. In physician-assisted suicide, the patients cause their own deaths subsequent to receiving some type of enabling help from their physicians. The patient is the agent who decides if and when to take the proffered drug.

6. Assisted suicide is unnecessary

Professionals involved in hospice programs are rightly proud of their accomplishments; many feel that the availability of hospice care now precludes the need for patients to seek assisted suicide; pain and symptom control are now so effective that no patients need to suffer. The National Hospice Organization is on record in absolute opposition to physician-assisted suicide initiatives because in its opinion good hospice care can relieve all suffering.

Counter: A number of hospice physicians grant that there may be a small subset of patients whose suffering cannot be alleviated; for these patients they concede that assisted suicide may be a reasonable alternative. Most would agree that even in the best of circumstances about 5% of severe pain cannot be relieved without causing unconsciousness. And, most importantly, suffering is not always pain. It also includes progressive disability; perhaps unrelieved nausea, vomiting, or diarrhea; and the necessity of dependence on

others as well as the possibility of dying in an undignified, unesthetic, and unacceptable condition.

The current interest in physician-assisted suicide is, in part, a response to the reality of current medical progress. The increased technological capability of modern medicine can now prolong life, but the actual situation is that the longer life may be dominated by pain, disability, deteriorating neurological function or progressive dementia.

Another change of note is in the epidemiology and demography of disease. Advanced industrial democracies (The United States, Holland, Germany) that can boast of sophisticated medical establishments have increasing populations of older persons because most people no longer die of infectious and parasitic diseases. Typically, 70 to 80% will die of degenerative diseases or cancer; diseases that are characterized by a late, slow onset and an extended decline.

7. Assisted suicide should not be legalized because of its effect on society.

This line of thought stresses the negative effects on our society; one which prizes the principle of the sanctity of human life. With the exceptions of war, self defense and capital punishment, our society does not condone taking life.

Counter: The answer to this argument has been articulated well by Loewy: "A society which condones killing in war and metes out death as a punishment cannot argue that life is an absolute good which must be preserved at all costs." [7] (New York has just reinstated the death penalty and is the 38th state to have this statute).

8. Slippery slope arguments

The fear is that if physician-assisted suicide is legalized the next step will be voluntary euthanasia, and then involuntary euthanasia. Advocates of this position point to the experience of Nazi Germany.

Counter: Euthanasia never did start as a voluntary proposition in Nazi Germany. It began and continued as killing of those considered undesirable. Adequate precautions must be taken. But with proper safeguards, extension of assisted suicide to euthanasia could be avoided. Some feel that because the current US system of withdrawing treatment is less conspicuous than assisted suicide, it invites fewer protections and may itself lead to undesirable extension.[10]

9. Assisted suicide would impose an obligation on the weak and ill.

Would patients enfeebled by disease and devoid of hope choose suicide not because they are tired of life but because they think others are tired of them? Or, to spare the family emotional and financial burden? Or, because they get signals from society that it would rather spend its resources in a other ways?[11]

Counter: These are the strongest arguments against legalizing euthanasia in the United States. This worry also underscores the need for a tight system of safeguards if assisted suicide were to be sanctioned in the US.

These concerns also indicate the need for involvement of a physician who knows the patient well and is aware of the patient's interpersonal relationships and outside pressures which might influence free choice. Unlike euthanasia, assisted suicide has an additional safety measure; it is the patient who initiates the final action.

An argument can be made that if physician-assisted suicide was made available, patients might feel they had more control over end-of-life decisions. This greater sense of control might encourage seriously ill patients to choose risky and unpleasant life-sustaining measures which occasionally succeed, knowing that they could cut short unwelcome consequences in well defined ways.[12]

10. Suicide is always irrational.

Not long ago all suicide was thought to be the result of mental aberration, usually depression. The standard response was, "No one in his right mind would want to take his own life."

Counter: Medical progress, has created the new situation in which the life being saved may not be considered worth living by the patient. Thus the concept of "rational suicide" while not common can be justifiable.

11. Religious and spiritual prohibitions against suicide

Many religions consider human life to be of infinite value and thus never to be shortened by human intervention under any circumstances.

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In this view the length of life is determined by God alone. This belief is not characteristic of all religions nor is it necessarily held by all members of a given religion.

Counter: The conflict in the current issue pits those who have an absolutist view of life, those who believe that the sanctity of human life always prohibits assisting with suicide against those who, in an identical situation, would maintain that, on occasion, compassion for human suffering permits assisting a suicide. As Morreim puts it, "The standoff is between the two basically irreconcilable viewpoints stemming from the abortion conflict. On the one hand are the "vitalists" who believe that all human life is supremely valuable regardless of its quality and thus must be preserved for as long as possible in all circumstances.

On the other hand, are the "qualitists" who believe that the value of life lies in its distinctly human quality and that there are some conditions under which life is no longer of value to the person who has it. Vitalists attempt to force qualitist physicians into preserving all life as long as possible in spite of their professional standards."[13]

Right-to-life groups and religious fundamentalists oppose physician-assisted suicide for the same reason that they oppose abortion. But, there is one important difference. In physician-assisted suicide the life concerned is not that of the fetus but of the self. The person contemplating suicide has made a determination that his or her own life has deteriorated to the point where further existence is a fate worse than death.

12. Redemptive suffering

Another religious thesis is that suffering has redemptive value. To some extent this argument is dependent on the ancient belief that illness is imposed by the gods (or God) as punishment for sins.

Counter: The physician's responsibility is to provide relief to those who do not wish to suffer. The choice remains with the patient.

U.S. initiatives

In 1985 a 12-member group of physicians was asked to address the issue of "Physician Responsibility Toward Hopelessly 111 Patients." The same group met again in 1989 to reexamine this topic. Their report emphasized an adjusted and sensitive approach to the care of the terminally ill including careful and timely discussion with the patient and adequate pain control without concern for secondary sedative effect.

All members of the group agreed that the decisional patient has the right to have treatment withdrawn and that euthanasia should not be legalized. But their conclusion about physician-assisted suicide was not unanimous:

"...(A)ll but two of us believe it is not immoral for a physician to assist in the rational suicide of a terminally ill person. However, we recognize that such an act represents a departure from the principle of continually adjusted care that we have presented. As such, it should be considered a separate alternative and not an extension of the flexible approach to care that we have recommended. Clearly the subject of assisted suicide deserves wide and open discussion."[14]

> "It's better for our society to let some people go through devastating misery before they die because the social cost of allowing doctors to (help) terminate their suffering is too high."

In 1991, Washington State Initiative 119 titled, "Physician Aid In Dying," got 223,000 signatures, more than enough to put it on the ballot. The bill's language did not make a clear distinction between euthanasia and physician- assisted suicide. The proposed legislation was opposed by the Washington State Medical Society and the Catholic Church, which mounted an extensive television campaign against it. The initiative failed by a vote of 54% to 46%.

In 1992 a similar "Death with Dignity Act" (California Initiative 161) failed by the identical margin of 54% to 46%. As in Washington, there was no clear distinction between active euthanasia and physician-assisted suicide. Some exit polling indicated that the public was not as concerned with the principle as with the perceived lack of safeguards.

A New York task force in 1994 gave a unanimous "no" to physician-assisted suicide out of concern about the "slippery slope." They did agree that some individual cases justified allowing physician-assisted suicide but felt that it was just too dangerous to make public policy.

Meier's commentary addresses the argument that it is "better for our society to let some people go through devastating misery before they die because the social cost of allowing doctors to (help) terminate their suffering is too high."

She says, "I would argue the reverse: the social costs of abandoning such patients—costs such as loss of faith in doctors, acceptance of callousness toward the suffering of the dying and the fear of modern medical practice--far outweigh the costs of easing constraints on physician assisted dying."[15]

In May 1994, Judge Barbara J. Rothstein of the U.S. District Court for western Washington ruled that the state's criminal prohibition of physician-assisted suicide was unconstitutional. She found a 14th Amendment "liberty interest" in making a decision as to when to end

one's life. "There is no more profoundly personal decision, nor one which is closer to the heart of personal liberty, than the choice which a terminally ill person makes to end his or her suffering and hasten an inevitable death."[16] On March 9 1995, a US Circuit Court overturned that judgment by upholding current Washington law. The case is now on appeal before the 9th US Circuit Court of Appeals in San Francisco.

In Oregon in November 1994, Ballot Measure 16 passed by a vote of 52% to 48%. The "Death with Dignity Act" allows a terminally ill, decisional patient to make a voluntary request to a physician to prescribe a lethal dose of medication.

A consulting physician who is qualified by specialty or experience must confirm the diagnosis and voluntary state of the request. If either physician believes that the patient has a treatable depression or a mental disorder impairing judgment, referral for psychiatric evaluation is necessary. Two voluntary oral requests must be made at least 15 days apart. Then a written request follows; the actual drug prescription may not be given until 48 hours later.

The law applies only to Oregon residents and physicians. Physicians who are opposed to the law are not obligated to take part. The law is currently under a temporary restraining order while a federal judge reviews constitutional issues. The injunction has been appealed to the 9th Circuit Court; it might be heard in April 1996.

Proposed criteria for assisting suicide

Quill, Cassell, and Meier proposed the following clinical criteria that would allow physicians to respond to requests for assisted suicide from their competent, incurably ill patients: "We support the legalization of such suicide but not of active euthanasia. We believe this position permits the best balance between a humane response to the requests of patients like those described above and the need to protect other vulnerable people." Criteria include:

- An incurable condition associated with severe, unrelenting suffering but not necessarily imminently terminal.
- The physician must ensure that the patient's suffering and the request are not the result of inadequate comfort care. Hospice care and all avenues of palliation have been explored and no other alternatives remain.
- The patient must clearly and repeatedly, of his or her own free will and initiative, request to die rather than continue suffering. The physician must know all the social-familial factors in order to be sure that the request is not motivated by external pressures.
- The physician must be sure that the patient's judgment is not distorted; that the patient is capable of understanding the decision and its implications and that it is a rational decision. Expert psychiatric evaluation should be sought to rule out a treatable depression.
- Physician-assisted suicide should be carried out only in the context of a meaningful doctor-patient relationship. The primary physician should personally confirm that each of the criteria have been met. If the assisting physician is not the primary physician, he or she should have witnessed the patient's previous illness and suffering.
- Consultation with another experienced physician is required to ensure that the patient's request is voluntary and rational. The diagnosis and prognosis is accurate, and the exploration of comfort-oriented alternatives thorough.
- Careful and complete documentation to support each condition is required."[17]

In a later paper, a physician group proposed that there be mandatory consultation with a certified palliative care expert: one with experience in symptom control, competency, identification of depression and pain control. They also advocated the establishment of regional palliative care committees for monitoring and oversight functions.[18]

Physician responsibilities

Regardless of one's personal response to the issue of physician-assisted suicide, in my opinion it is, incumbent on each physician to be well informed of the arguments, pro and con; to consider the issues carefully; and to avoid knee-jerk slogan-like responses. There are legitimate and compelling arguments on both sides of this issue. Because our society remains pluralistic, well motivated and caring physicians will draw opposite conclusions about appropriate action. Every physician needs to give careful thought to what his or her personal response will be.

In addition, each physician must

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do what he or she can to diminish the public mistrust of the medical profession that is manifested by the political initiatives to legalize euthanasia by:

- Always making patients full, informed partners in the decision making process;
- Assuring patients of their ability to maintain control of medical treatment by refusal of unwanted treatment, and the right to terminate treatment which has already begun;
- Initiating the discussion of advance directives and urging their completion so that patients may express their desires;
- Assuring that maximum therapeutic efforts are not prolonged unduly and that there is a return to emphasis on caring rather than curing when cure becomes unlikely. The emphasis then should be exclusively on pain control and comfort measures; and by
- Educating patients to understand medicine's limitations and to have more realistic expectations about what medicine can accomplish.

Personal thoughts

The two factions--those whose guiding principle is the absolute sanctity of life and those whose major goal is compassionate relief of unrelenting end of life suffering--will never come to common ground. In our pluralistic society, the most we can ask for is mutual understanding of the divergent positions and tolerance of the viewpoint of the "other."

While each has the right to voice concerns and opposition, it is not right for one group whose actions are motivated and restricted by a certain set of values to impose the same restrictions on others who may have a different value system. Certainly our forefathers decided that, in matters of religion, this sort of coercion should not occur in this country.

There are rare instances in which physician-assisted suicide might be a regretful but appropriate response to an intolerable medical disaster. That decision by a suffering patient and a compassionate physician should be a very private and personal matter. Why should anyone outside of the doctor-patient relationship have the right to intervene?

I continue to oppose euthanasia, but have come to believe that physician-assisted suicide can be an ethical option in rare and circumscribed situations.

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Public health

A breast and cervical cancer screening intervention at public health influenza clinics, Dane County, Wis

Katherine M. Kvale, PhD; Karen Derrick Davis, MSSW; Kathleen Sullivan Paul, BSN, PHN; Wendy L. Schell, MS; and Patrick L. Remington, MD, MPH, Madison

Each fall in Wisconsin, over 200,000 older adults visit public health clinics to receive an influenza vaccine (Wisconsin Division of Health, unpublished data). These clinics provide an opportunity to educate women about the importance of other preventive services, such as mammography and Papanicolaou (Pap) smear tests. In the fall of 1994, we surveyed all women who attended influenza vaccine clinics at selected public health clinics in Dane County, Wis. The purpose of this project was to assess current screening practices for breast and cervical cancer of women aged 50 and over and to provide a low-cost, breast and cervical cancer intervention.

Methods

The project was conducted among women 50 years of age and older at all the influenza vaccine clinics offered by Dane County Human Services Department, Public Health Division, during October and November, 1994. Twenty-eight influenza clinics, scheduled by appointment, were held at 12 sites throughout municipalities in Dane County, excluding the city of Madison. The area of the county served has a suburban and rural population of approximately 74,000 persons.

Each woman attending the clinic completed a short questionnaire, asking if she had had a mammogram in the past year or a Pap test in the past 3 years. She was then offered National Cancer Institute brochures ("A Mammo-gram Could Save Your Life," "Take Care of Your Breasts," "Having a Pelvic Exam and Pap Test," "The Pap Test: It Can Save Your life"). Finally, each woman visited with one of us (KSP or KD) to discuss screening guidelines, self breast exam (using a breast model), Medicare coverage, and eligibility for the Wisconsin Women's Cancer Control Program, a screening program for low-income women funded by the CDC.[1]

Information from the interviews was recorded on a questionnaire and analyzed using Epi-Info software. For comparison purposes, we analyzed breast and cervical cancer screening rates from the 1993 Wisconsin Behavioral Risk Factor Surveillance System (BRFSS), a random digit dialed telephone survey of the health practices of Wisconsin adults. The telephone survey data were analyzed using SAS software, and prevalence rates were adjusted to the 1990 Wisconsin population of women aged 50 and older.

Finally, the costs of this project were determined based on labor cost ($25/hour for salary and fringe) and the cost of printing and materials.

Results

Six hundred and thirty two women 50 years of age and older attended the Dane County influenza vaccine clinics. Forty-eight (8%) women declined to participate in the project. The remaining 584 women (92%) completed the survey and responded to the questionnaire regarding their breast and cervical cancer screening practices (table).

About half (48%) of women seen at the clinic reported having had a mammogram in the past year. Screening rates were highest among

Table: Percent of women seen at influenza clinics who reported having had a mammogram and Pap test, Dane County, Wis, 1994.

Age	Number	Mammogram in past year	Pap test in past 3 years
50-64	57	67%	70%
65-74	282	51%	67%
75-84	191	43%	58%
>=85	54	24%	39%
Total	584	48%	62%

The public health column is not reviewed by the *WMJ* Editorial Board. This work was funded by a grant from the National Cancer Institute (RO1-57014). Kvale and Schell are epidemiologists in the Chronic Disease and Health Promotion Section, Bureau of Public Health, Wisconsin Division of Health. Davis is program coordinator of the Wisconsin Women's Cancer Control Program of Dane County. Sullivan Paul is prevention coordinator, Dane County Human Services Department, Public Health Division. Remington is chief medical officer of the Chronic Disease and Health Promotion Section, Bureau of Public Health, Wisconsin Division of Health. Address reprint requests to Patrick Remington, MD, Wisconsin Division of Health, 1414 E. Washington Ave., Room. 167, Madison WI, 53703. Copyright 1995 by the State Medical Society of Wisconsin.

women aged 50-64 years, and declined with increasing age. In contrast, almost two-thirds (62%) of women seen at the clinic reported having had a Pap test in the past 3 years. As with mammography, Pap testing rates decreased with increasing age (figure).

After age-adjustment, women in the clinic were more likely to report a mammogram in the past year (55% versus 45%) and were about as likely to report a Pap test in the past 3 years (64% versus 62%), compared with women in the general population.

The project required approximately 40 hours for planning and three hours to deliver the intervention at each of the 28 clinics. Labor costs ($3,100), combined with the costs of materials and printing ($30), amounted to $5.36 for each of the 584 participants.

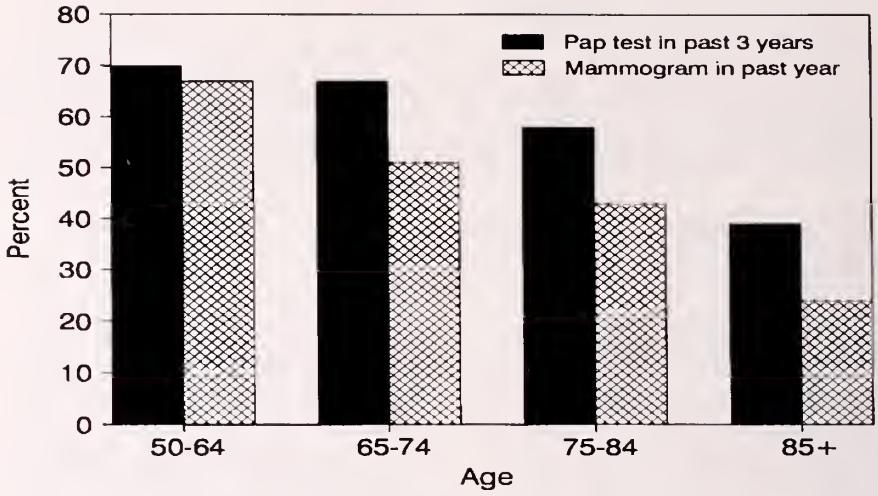

Fig.--Percent of women seen at influenza clinics who report having had a mammogram in the past year and Pap test in the past 3 years, Dane County, 1994.

Discussion

This project demonstrated that public health influenza clinics can be used to reach older women--an important target population for other public health initiatives. This project captured a "teachable moment" for an interested audience of women concerned about their health--as evidenced by their seeking an influenza vaccine. Client time for the project was easily incorporated into the routine of the clinic and almost 600 women were reached in one month. Finally, this project provided women with useful information regarding Medicare and Wisconsin Women's Cancer Control Program eligibility.

This project also raised important questions about promoting cancer screening among women of different ages. Most organizations recommend regular mammograms and Pap tests for women ages 50 to 64. This project clearly showed that, similar to the general population, there were many women seen at the clinic in this age group who were not receiving regular mammograms and Pap tests, and who would benefit from this intervention.

In contrast, there is little consensus on the benefit of regular mammography and Pap tests among women age 75 and older.[2-4] For example, the U.S. Preventive Services Task Force recommends that mammography be discontinued at age 75 if no pathology exists and that Pap tests be discontinued at age 65 if previous smears have been consistently normal.[4] Despite these recommendations, many women age 75 and older report receiving regular mammograms and Pap tests.

There were limitations to this project. We did not assess reasons and barriers for not having a cancer screening test. It would be important to know if women were aware of the need for mammograms and Pap tests, but had not had them, versus being unaware of the need for the tests. Additionally, the data were analyzed from self-reports. Mammography self-reports are usually accurate, but self-reports for Pap test may be confused with a pelvic exam and may not be as accurate.[5]

In summary, given the current budget constraints for preventive health programs, and as program dollars become more scarce in the near future, the health care system must become more efficient and comprehensive with the funds available. This intervention aptly shows that an educational outreach intervention for breast and cervical cancer screening is easily conducted at a public influenza vaccine clinic with little additional staff time and resources.

Acknowledgements

The authors thank Nancy Chudy, MPH; John Fox, MD; and Laurie A. Garrett, MSPH, for technical assistance.

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Mutual funds and unit trusts

Michael J. Dolan, CLU,ChFC, Madison

WANT TO INVEST without a lot of money? Want to invest without expert knowledge? Without taking the considerable time required to monitor the progress of individual investments? Mutual funds or unit trusts may provide the answer.

Both mutual funds and unit trusts are pooled investments, enabling the small investor to make larger investments by combining funds with other people. Both can offer a variety of investments, from government securities to corporate or municipal bonds. But there the similarities end. If you're considering a pooled investment, here's what you need to know.

Mutual funds are open-ended; they have no fixed maturity date. They are professionally managed; investments within the fund are bought and sold, at the discretion of the fund manager, to meet fund objectives in a changing economic climate.

There are mutual funds to meet virtually any investment goal: growth, income, security. There are mutual funds in virtually any type of investment vehicle; common stock, corporate bonds, tax-free bonds, options, even money itself (via a money market mutual fund). And there are special-interest mutual funds: in one industry (commonly called sector funds), for example, or one country.

When you choose to invest in mutual funds:

- Inquire about fees and charges. All funds have annual administrative charges. All funds have annual administrative charges; some also have up-front fees called "loads" which can be as much as 8.5 percent of your initial investment. "No-load" funds are typically sold by mail and load funds through a stockbroker; some "low-load" funds are available either way. (The "load" or "no-load" concepts do not affect fund performance.)
- Look for a fund that belongs to a "family" of funds, so that you can easily switch your investments as your objective change or economic circumstances dictate.
- Elect Automatic reinvestment, instead of taking dividends and capital gains distributions in cash, and your investment will grow.
- Find out how easy it is to purchase shares: What is the minimum purchase amount? Will the fund accept automatic deductions from your savings or checking account? To withdraw your funds, can you write a check? Must you fill out forms and have your signature guaranteed?

Unit investment trusts, in contrast to mutual funds, are closed end investments with fixed maturity dates. They are unmanaged --- with the portfolio, and therefore the return, fixed at the time of purchase. Unit investment trusts are sold only by stockbrokers, who receive commissions on the sales, and should be considered longterm investments.

Michael J. Dolan, CLU, ChFC

When you choose to invest in unit trusts:

- Ask about sales charges, which typically range from 2.5 to 5.5 percent.
- Choose a maturity date to meet your own needs; an intermediate-term bond trust, for example, might run 10 or 12 years and a long-term trust 20 or 30 years.
- Decide whether to take interest by monthly or semi-annual checks, or to reinvest the interest and compound your return.❖

Dolan is vice president and chief operating officer of SMS Insurance Services and a member of the National Association of Life Underwriters.

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Hamming it up with Ray! Marcia Richards, MD, SMS President (center) and her husband Donald Whitaker (right) and Steve Whittow, SMS field rep (far left) enjoy the day with Ray Nitschke, former Green Bay Packer great who served as celebrity host of the CESF Charity Golf Classic.

Rest in Peace
A hardworking physician's search for sleep

Ponara Eng, SMS summer intern

"SWEET DREAMS," we tell our children as we tuck them into their beds. But the sleep that brings those dreams eludes many Americans each night, prompting some hard-working doctors to examine why.

In 1990, Dr Michael Katzoff, along with Dr William O'Neil, helped to launch the opening of the Sleep Disorder Clinic at St. Luke's Hospital in Milwaukee. Since then, the clinic has garnered statewide respect and admiration for its complete system of diagnosis and treatment. Central to its success is Dr Katzoff.

Dr Katzoff, a pulmonary specialist, earned his medical degree from the New York Medical College and went on to serve his residency in internal medicine in Stamford, Conn. In 1979, he moved to Wisconsin and worked in pulmonology at the Medical College of Wisconsin, in Milwaukee. He has been in the Milwaukee area ever since. Dr Katzoff became certified in sleep disorders in 1990 and has gradually shifted his focus from pulmonology to sleep disorders.

Over the years, Dr Katzoff has helped to treat hundreds of patients with everything from chronic insomnia to severe sleep apnea. "We get an amazing number of our new patients from word of mouth," he says. Perhaps the reason the word is spreading about the clinic is because of its thorough and professional approach to sleep disorders. Dr Katzoff doesn't compromise on patient care.

"I believe in the dignity of each person, that everyone is entitled to caring, compassionate, professional care." It is that principle that drives both the clinic and Dr Katzoff. "One of the keys to our success has been the fact that we spend so much time with our patients, staying in contact, educating them, and checking their progress."

One of the major ailments of patients who come to see Dr. Katzoff is insomnia. At some point or another, a full one third of all Americans suffer from insomnia. Because of the variety of factors that contribute to insomnia, Dr Katzoff believes in a multi-speciality approach, often calling in psychiatrists and other specialists as consultants.

Dr Katzoff also believes in educating his patients on proper "sleep hygiene rules."

"The problem with many of our patients is that they don't see the bedroom as a place for quiet, rest and tranquility, but as a place to watch television or read things that will keep them awake," he says.

Dr. Katzoff's hygiene rules include no alcohol or tobacco, no caffeine or other stimulants, and no stimulating videos and books in the bedroom. "Alcohol may make you tired and put you to sleep but the quality of sleep is not going to be as good."

He also warns against laying in bed and worrying about problems, such as bills or relationships. "Set a time in the day to think about those things. Write down the problems and what you intend to do, but don't do this all in your head when you should be sleeping."

Another no-no is changing your sleeping times. "One of the keys to getting consistently good sleep is to go to bed at the same time every night," Katzoff relates.

A patient arriving to the clinic for the first time should expect a physical examination and a comprehensive history. Dr Katzoff wouldn't have it any other way. "The symptoms of sleep disorders are also the symptoms of other conditions," he explains. " For example, depression often mimics sleep apnea, in that the patients are constantly tired and often feel that they haven't gotten enough sleep; that's why we have to be sure of the condition before we can consider treating them."

If the history and physical point towards a sleep disorder, the patient would then take a polysomnogram, which monitors a patient's physical measurements during sleep. A polysomnogram often verifies that the patient may have sleep apnea, which is a condition that occurs when air flow is completely blocked and the patient momentarily stops

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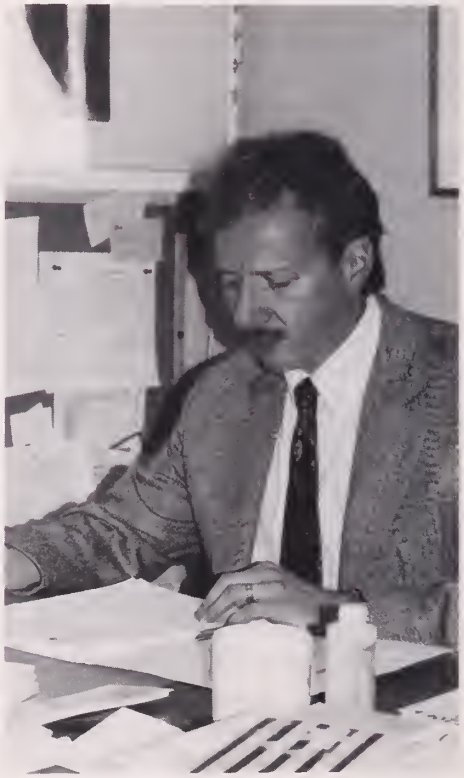
Sleepless in Wisconsin?

Taking a polysomnogram is like checking into a fine hotel, plus a little extra equipment.

Dr Katzoff welcomes patient Sheri Moschetz in for a follow-up check.



Dr Katzoff reviews notes on a patient's progress. *Photos by Ponara Eng*

Continued from page 519
breathing during sleep. Severe sleep apnea occurs in 4% of adult men and mild apnea affects as much as 24% of adult men. Besides causing a person to snore loudly and wake up tired, apnea has also been linked to heart attacks, strokes, motor vehicle accidents and high blood pressure. It also has negative effects on a person's libido, energy, mood, and stress level. Proper treatment, therefore, can dramatically improve a person's life.

Taking a polysomnogram is much like checking into a friendly, comfortable hotel room. There is a queen-sized bed with a comfortable, home-style quilt and a television. The idea is to make patients feel at home, and fall asleep, so that the instruments can monitor everything from heart rate to body temperature.

"We use what we call a split night technique, we combine what would normally be 2 nights of study into one night. We let the patient fall asleep, and if our instruments indicate sleep apnea, we wake them up and have them try C-PAP," Katzoff explains.

C-PAP, or Continuous Positive Airway Pressure is a small mask that is connected to an air tube, which pushes small amounts of air throughout the night through the nostrils, spreading apart the tissues in the throat that obstruct the patient's breathing. Although not a cure, the C-PAP is the mainstay treatment for severe disease at the clinic. "It works great, and its self-enforcing, in that patients continue to use it because it makes them feel great the next day."

Dr Katzoff has seen the C-PAP change many lives for the better. "We have people that used to be grumpy, anxious and tired, (who now) wake up and live much more active lives...they're not couch potatoes anymore."

That hard-earned success with patients helps Dr Katzoff and other clinic staff sleep better at night too.❖

President Clinton names Dr Richard J. Boxer to the National Cancer Advisory Board

Richard J Boxer, MD, of Milwaukee, a urologic surgeon and an associate professor at the Medical College of Wisconsin has been appointed by the president to serve on the National Cancer Advisory Board. Dr Boxer has served as chief of urology at Mount Sinai Medical Center from 1982 to 1983; chief of urology at St Michael Hospital from 1987 to 1991; associate chief of surgery at Mount Sinai Medical Center from 1987 to 1988; and chair of the Department of Surgery at St Michael Hospital from 1991 to 1995. He is the medical advisor to two prostate cancer foundations and the Wisconsin Prostate Cancer Support Group and has won a national award for cancer research. He has lectured around the world and has written over 40 chapters and scientific articles on prostate, kidney and bladder cancers.

Dr Boxer is the only member of the Health Policy Institutes at both the University of Wisconsin-Madison and the Medical College of Wisconsin.

Dr Boxer was recently appointed by Secretary of Health and Human Services Donna Shalala to the Board of Advisors of the National Institutes Digestive, Diabetes, and Kidney Diseases (NIDDK). This 15 member national board oversees the research and sets policy for the $800 million dollar NIDDK.

The National Cancer Advisory Board was created in 1971 to advise and assist the director of the National Cancer Institute with respect to the National Cancer Program. Each year, the board submits a report to the president for transmittal to the Congress on the progress of the national cancer program. The board consists of 18 members appointed by the president for 6 years.

The National Cancer Institute conducts and supports $2.1 billion dollars in basic and clinical cancer research in prevention, early detection, diagnosis, treatment and rehabilitation.

Richard J. Boxer, MD

Dr Boxer is a urologist who practices at St Michael, St Mary's and Sinai-Samaritan Hospitals. He has been on the board of directors of eight philanthropic organizations.❖

County society news

Door-Kewaunee. The Door Kewaunee Medical Society approved membership for Maurice W. Chung, MD; Scott Hathaway, DO; and Scott Feole, MD.

Eau Claire-Dunn-Pepin. The following physicians have been approved for membership in the Eau Claire-Dunn-Pepin County Medical Society: Theresa M. Cheng, MD; Christine Blobe Redmann, MD; Kathleen M. Tonti-Horne, MD; David B. Winter, MD; and Todd R. Wright, MD.

Jefferson. Jeffrey P. McGuire, MD, was elected to membership in the Jefferson County Medical Society.

Marathon. The Marathon County Medical Society approved membership for Elisabeth T. Madagame, MD; and Thomas C. Wald, MD.

Oneida-Vilas. The Oneida-Vilas County Medical Society met on June 8, 1995, at Jacobi's restaurant in Hazelhurst, Wisconsin. The guest speakers were Mark Adams, SMS legal counsel, and Jim Reuter, field staff representative. Jim Keuer, MD, received recognition as a recently elected district representative to the SMS. Laura Nelson, MD; and Matthias Weiss, MD, were approved for membership.

Outagamie. The Outagamie County Medical Society approved membership for Avi Bar-Lev, MD; William C. Guenther, Jr, MD; Brian A. Hebl, MD; Thomas A. Ryan, MD; John D. Swanson, Jr, MD; Peter F. Ullrich, Jr, MD; and Philip A. Yazbak, MD.

Taylor. Eric H. Locher, MD, was approved for membership in the Taylor County Medical Society.❖

Call for abstracts

The American Radium Society (ARS) would like to encourage readers to submit abstracts on cancer research to be presented at the ARS Annual Meeting in San Francisco March 30-April 3, 1996. The American Radium Society is the oldest multi-disciplinary oncologic society in the US. Physicians and scientists from all disciplines involved in cancer management are encouraged to submit abstracts. Abstracts linking current cancer treatment to treatments of the future are preferred, although other abstracts, either clinical or basic science, are welcome. The abstract submission deadline is October 16, 1995. For further information contact: American Radium Society, 1101 Market Street, Suite 1400, Philadelphia, PA 19107. The phone number is (215) 547-3179; the fax number is (215) 923-1737, and the e-mail address is ars@acr.org. ❖

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Nominations sought for the "Country Doctor of the Year"

NOMINATIONS ARE NOW being accepted for an award honoring the nation's quintessential country doctor.

The "Country Doctor of the Year Award" is bestowed on the rural medical practitioner who best exemplifies the spirit, skill, and dedication of America's country doctors. Now in its third year, the award is co-presented by Staff Care, an Irving, Texas-based interim physician staffing service, and the Country Doctor Museum in Bailey, NC.

"We're looking for the kind of doctor who still makes house calls," says Joseph Caldwell, vice president of Staff Care. "The kind of small town physician who's been paid in produce and who has delivered most of the kids on the high school basketball team."

The nominated physician must practice in a community of 20,000 people or less, have a record of at least 3 years of continuous service in the community, provide a high quality of care, and show extraordinary dedication to his or her patients.

Nomination forms may be ordered by calling Staff Care, toll-free, at (800) 685-2272.

A Plaque and a Place in History

The Country Doctor of the Year will receive a personalized bronze plaque depicting the award's signature logo -- a country doctor making his rounds on a horse and buggy. In addition, Staff Care will provide the honoree with an interim physician for one week, at no charge, a service valued at about $10,000, according to Caldwell. The interim physician will cover the Country Doctor of the Year's patients while he or she takes a well deserved rest.

In a special honor, the award recipient will be recognized by the County Doctor Museum, the only museum in the nation specifically dedicated to memorializing the contributions of America's country doctors. The museum will display a bronze plaque bearing the honoree's name, thereby securing the Country Doctor of the Year a place in the annals of rural medicine. Both past recipients of the award, Dr John Haynes of Vivian, Louisiana, and Dr Claire Louise Caudill of Morehead, Kentucky, have been honored in this way.

A Vanishing Breed

According to Caldwell, the award is meant to throw a positive light on rural medical practice at a time when country doctors are a vanishing breed.

"Like the horse and buggy itself, the old time country doctor is a fixture of America's past," Caldwell says, "but the future of rural medical practice is very much in doubt."

Several statistics underline Caldwell's statement. Twenty percent of rural physicians are older than 65 (compared with 15% nationally), yet only 1.5% of graduating medical students desire a rural practice, according to the Association of American Medical Colleges. In an alarming trend, there are now over 110 rural counties throughout the US that have no physician at all.

"Country doctors are still the primary source of medical care for over 65 million Americans," Caldwell states. "By recognizing the great contributions of rural medical practitioners through the award, we hope to encourage more young people to pursue this rewarding style of practice."

Nominations may be submitted by colleagues, patients, relatives and friends of country doctors and must be received by Staff Care by Sept 30,. The award recipient's name will be announced on or about Nov 2.❖

AMA awards

THE WISCONSIN PHYSICIANS listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates members of the SMS.

* Bartholmai, Jack R.
Bianco, Jesus
* Cortte, Ronald G.
Gladieux, John R.
* Hughes, Jack L.
* Iorio, Louis J.
* Kammholz, Larry P.
* Kennedy, Jane E.
* Lyerla, Eric R.
* Malone, Edward J.
* Newman, Douglas J.
Quinn, Kevin V.
* Reiskytl, John R.
Roh, Byung L.
* Snow, Patrick D.
* Weinlander, Chris M.❖

Obituaries

Mullaney, Gerald L., MD, died June 26, 1995. He graduated from Creighton Medical School in Nebraska. He served in the US Army during World War II, and again following medical school. He served his residency in OB-GYN at St Louis University Hospitals. He practiced in the Milwaukee area until his retirement in 1992, serving on the staff of Columbia Hospital for 36 years. He was also on the staff of St Mary's and St Michael's Hospitals. Dr Mullaney is survived by his wife, Mary; four sons, Timothy, of Stevens Point, Kevin, Madison, and Gerald L. Jr, and Peter, both of Shorewood; two daughters, MaryAnne, Whitefish Bay, and Margaret Vartanian, Shorewood.

Nice, Marvin L., MD, died June 28, 1995. He was a graduate of Northwestern University Medical School in Chicago. He was a captain in the US Army, serving in Japan from 1967 to 1969. He practiced medicine in Kenosha from 1969 to 1995. Dr Nice was a member of the State Medical Society and the Kenosha County Medical Society. He is survived by his wife, Doris; a son, David J., Charlottesville, Va; a daughter, Julia A. Greenleaf, Missoula, Mont; and his mother, of Winamac.

Watts, Alice D., MD, died June 24, 1995, in Oregon. Dr Watts was born on August 26, 1906. She graduated from the University of Wisconsin School of Medicine in 1931. She practiced family medicine in Westchester County, NY, before specializing in obstetrics and gynecology. She moved to Milwaukee and was the first woman doctor in the field in southern Wisconsin. She was affiliated with the Stoughton Hospital when she moved her practice to rural Oregon. She practiced medicine for 53 years, retiring in 1984. Dr Watts was a member of the State Medical Society and the Dane County Medical Society. Dr Watts is survived by a sister, Mary Sondern of Oregon. ❖

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.❖

Nominating Committee solicits nominees

The House of Delegates Nominating Committee has put out a call to SMS directors and officers, officers of county medical societies and specialty sections as well as SMS and AMA delegates requesting nominations for several SMS offices.

The nominating committee will consider and interview candidates for the following posts: president elect for 1996-97; vice speaker of the House of Delegates for 1996-98 - *Michael C. Reineck, M.D., of West Bend; AMA Delegates for calendar years 1997 and 1998: *Cyril M. Hetsko, M.D., of Madison; *John P. Mullooly, M.D., of Milwaukee; *Richard H. Ulmer, M.D., of Marshfield; AMA Alternate Delegates for calendar years 1997 and 1998: *Jerome W. Fons, Jr., M.D., of Greenfield; *Kevin A. Jessen, M.D., of Tomah; *Robert F. Purtell, Jr., M.D., of Milwaukee. (Candidates with an asterisk in front of their names are eligible for re-election.) In addition, nominations are being accepted for the position of House of Delegates speaker in the event that position would become available at a future date.

The House of Delegates Nominating Committee will meet this year in conjunction with the SMS Board of Directors meeting, Saturday, Oct. 7, at SMS headquarters in Madison. The committee will present a proposed slate of officers at the 1996 annual meeting in April in Milwaukee.

Communications to the Nominating Committee should be addressed to it in care of Thomas L. Adams, C.A.E., executive vice president, SMS, P.O. Box 1109, Madison, WI 53701. All candidates should submit a curriculum vitae with a cover letter.❖

Senior physicians outing

The Wisconsin Senior Physicians enjoying their outing at the Mitchell Park Domes in Milwaukee on Saturday, June 10.

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Ranked 23rd in *100 Best Small Towns in America,* Monroe, Wisconsin, boasts a strong economy, year-round outdoor activities, a comprehensive and diverse school system, and many amenities for an excellent quality of life. Madison, WI, Dubuque, IA, and Rockford, IL, are just an hour away, while Chicago and Milwaukee are within an easy two-hour drive. When you're thinking about a setting for your professional practice and the "good life" for your family, give some thought to Monroe.

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PRIMARY CARE PHYSICIAN WANTED - IMMEDIATE OPENING. Aurora Indiana/South Eastern Indiana. Due to health reasons, Dr. Ivan T. Lindgren has decided to retire (effective August 1, 1995). Dr. Lindgren has been practicing medicine since 1957, and started seeing patients at his current location August 3, 1970. Dr. Lindgren is currently seeking someone to take over his family practice. Rural community, loyal patients. 1,000 patients. Fully experienced staff. Industrial accounts. Area doctor support. School work: sports physicals, pee-wee football. Office building: x-ray machine, EKG, lab service, 4 patient examining rooms, executive office, reception area, computer system, fully experienced staff. Easy access to Cincinnati, Ohio: riverfront stadium (Bengals, Reds), symphony, performing arts. Interested parties should contact: Loomis Lindgren, home (517-349-6180), work (517-676-3000); Reid Hensley, home (812-926-4159), work (513-681-2200); Dr. Lindgren's office (812-926-2134). 9/95

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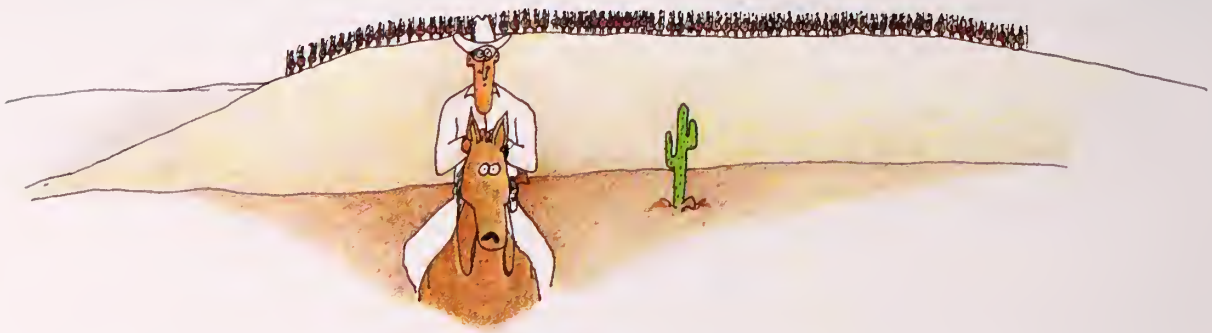

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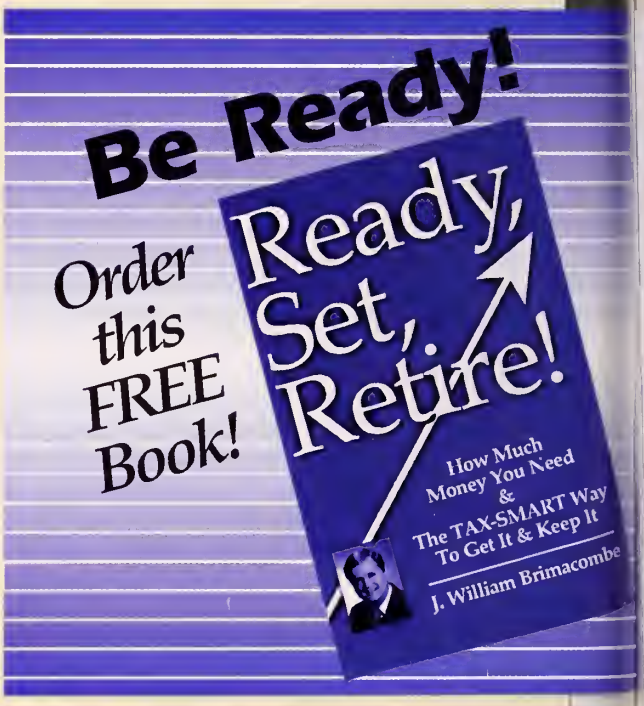
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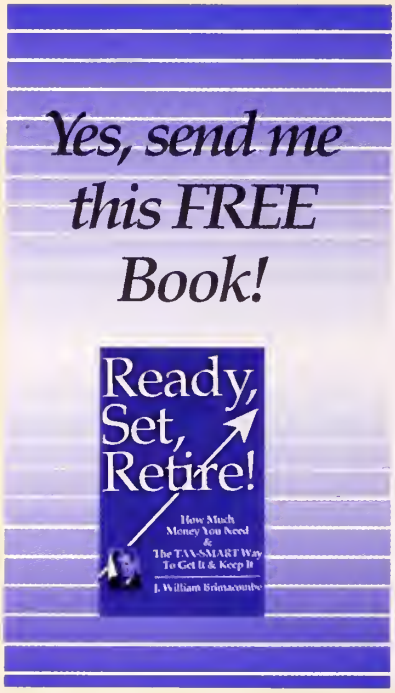

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Created by the Territorial Legislature in 1841 and now representing nearly 8,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal*.

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Our cover: "Body Memories - An Exploration of Breast Cancer in Marble," comprised of 33 marble sculptures created by artist, Susan Falkman is at once a heartfelt tribute to a close friend and an in-depth exploration of a major woman's health issue. "Body Memories" has been shown at Cardinal Stritch College in Milwaukee, in Cleveland, and Minneapolis and is scheduled to be shown in Wichita, Dayton, and Pittsburgh in 1996. Falkman is an accomplished artist who has exhibited her work in Italy, Greece, Australia, France, and the United States. Those who have experienced "Body Memories" have said, "I feel very moved by the beauty and depth of the pieces and the words of women." "...This is great art that speaks to the heart, I am in awe." "Your work is incredible, sad, terrifying, comforting, tender, inspiring..." "It reaffirms my feeling of how wonderful women are - with or without a breast." "This exhibit needs wide exposure, it is powerful!" For information about "Body Memories," please contact Susan Falkman, 414-243-5210. Falkman's other sculptures in marble can be seen at the David Barnet Gallery in Milwaukee, 414-271-5058.❖

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President's page
Who will pay for our future?

"He that will not apply new remedies must expect new evils"
--Francis Bacon

As a young physician, I once helped care for a friend who had breast cancer. Although her cancer was small, her node dissection (done at the time of mastectomy) revealed 40 nodes involved with metastatic disease.

Sitting across from her at the consultation, I knew that it was unlikely that she would be alive 5 years from that day. Gently, I told her of the dismal prognosis posed by the extent of her disease with the then-current standard therapy. But almost simultaneously, I also told her of the early results reported by an Italian physician on the use of three drugs given as adjuvant therapy to women with breast cancer with involved nodes; more women were surviving longer, disease free.

I advised her that an American cooperative group was testing the efficacy of a similar regimen in a clinical trial, and requested that she participate. I indicated to her that she had the potential to benefit not only herself, but also other women in the future. The information provided by the trial would, hopefully, make physicians like me smarter by providing us with new clinical information.

Today when I sit across the room with other women who also have breast cancer with metastatic node involvement, I no longer have to say that I don't know if adjuvant systemic treatment is beneficial. Instead, I can relate to them that it is standard therapy for women with their stage of disease, and can quantitate to them the potential benefits. I have this information based on the results of clinical trails, like the one in which my friend participated. I am also able to tell my patients, as a consequence of other trials, that most women with breast cancer today have the option of breast conservation or mastectomy--treatment choices that were unavailable to my friend.

Marcia J. S. Richards, MD

All of us routinely sit across from patients for whom we do not yet have answers determing the best treatment for their particular medical problem. Fortunately, as clinical research pushes the borders of medical knowledge, these patients and their problems change as we gain answers to old questions and begin new inquiries.

Lately I have begun to have concerns about a potential stumbling block that may serve to reduce or eliminate the clinical trials we have come to depend on for vital research.

Until recently, the direct costs for patient care in clinical trials were usually underwritten by an individual's health insurance with few questions asked. Today we find that insurers may often refuse

to cover a patient's costs when they are enrolled in clinical trials, especially if they happen to be covered under a managed care contract. I have been told that an informed consent for clinical trial participation in a patient's chart is often a red flag for denial of claims under many HMO plans.

Denials for care when our patients participate in clinical trials may occur because the payer of care (which may be an insurance company or employer) is only willing to allow the lowest cost treatment option for patient care, or because they interpret any trial as experimental.

As physicians, we must respond to this attack on future medical progress. No one--patient or physician--can afford to have medical advancement halt. We must work together for reasonable policies that assure an ability to continue to test new medical approaches.

To pave the way for continued clinical testing, however, we must make sure our slate is clean. Medicine, in my opinion, is not beyond reproach; we have not always made the best possible choices in terms of resource allocation. How often have we embraced and touted new technologies without a clear indication of their effectiveness? How often have multiple competing clinical trials been mounted without adequate patient accessions to answer the posed questions, when cooperation would most likely have given an answer? How often have we failed to ask and answer simple, non-elegant issues of medical care, preferring to pursue instead those that are more sophisticated and high tech? And how often have we not been fiscally sensitive or responsible in designing trials?

Society, likewise, is not without culpability. Successful lawsuits demanding newer, more costly treatments (i.e., autologous bone marrow transplant for high risk women with breast cancer) without conclusive proven benefit have fueled the current situation. Also, demands or choices for more costly therapeutic approaches by patients have contributed to the current backlash on clinical trials.

We need to be willing to hold a mirror before ourselves when we recommend medical procedures and treatments, and consider implementation of clinical trials. We must be sure decisions to proceed are made in a manner most cost effective in design and with the greatest potential benefit for society.

After our house is in order, I believe we should go hand-in-hand with our patients to pursue ways in which clinical questions can still be addressed, and, hopefully, find ways to gain answers quickly within our current evolving health care system. This is especially important as we see increasing numbers of individuals of all ages move into capitated insurance plans.

I fear if we are unsuccessful in ensuring the option of enrolling our patients in clinical trials, then tomorrow when we sit across from our patients, you and I may be potentially no smarter than we were yesterday. American medicine, known worldwide for innovation and progress, may be tragically frozen in time. Let's work to ensure there is no medical ice-age.❖

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EVP report
Making organized medicine 'user-friendly'

WHILE PRESIDENT, George Bush often voiced his dream that some day there would be a "kinder, gentler" America. Like many things Bush did or said during his presidency, that sentiment was received with some skepticism by the general public. Some people thought the world's greatest superpower must only be viewed as strong and effective; to introduce a kinder, gentler" element might set up an impossible paradox--one that might weaken our country's image at home and abroad.

The same perception held firm for many employers, businesses and professionals, based on the deeply entrenched American conviction that to be successful, we must put all else "on hold" and strive to be the best. Finally, that perception is beginning to fade, replaced by the belief that a healthy balance of work and family life provides the key to both personal and professional success. More physcians than ever before are finding ways to cut down on their work hours so they can spend more time with their families. That's especially true among doctors with elementary and preschool children.

This month, the SMS will embark on a new path toward making the medical society kinder and gentler for its members or, to pull a phrase from our fast evolving computer lexicon, more "user-friendly."

For longer than most of us can remember, the SMS annual meeting contained both policy-making and scientific meetings. Under the old school of thought, physicians were expected to be so involved with their calling that they thought little of spending yet another weekend away from their families, pursuing education and developing policies toward increasing and maintaining medical excellence.

Now, although no less committed to excellence, physicians are mirroring the attitudes found throughout America's workforce. We all have realized that as fulfilling as our careers can be, we also need time for ourselves and loved ones. Our members have made it plain that their families are too important to them to be left "on hold." In addition to keeping up with medicine's fast-paced changes, Wisconsin physicians like other professionals want to kick back, relax and have some fun. Maybe play a little golf or swim. We want to be there to help as our kids and grandkids experience the joys of growing up.

That's why, we at the SMS are so enthused about the new primary care forum set for Oct 27-29 in Pewaukee. This weekend truly has something for everyone--physicians regardless of specialty, spouses and families.

There are top notch scientific sessions planned on primary care issues with CME credit. We'll be presenting information on medical-related legal issues and emerging computer databases to help you quickly access information vital to your medical practice. We've planned forums on combating violence and substance abuse--two of our nation's gravest public health problems--on our streets and in Wisconsin homes. And we've got the latest information you'll need when considering practice affiliations and provider networks.

In between these educational opportunities, we blocked off plenty of family and relaxation time. There's a cracker barrel social where you and your spouse can meet to share food and conversation with other physicians and spouses in an atmosphere where kids and laughter are not only allowed, but encouraged.

Thomas L. Adams, CAE

At the Oct 29 Halloween party, you will have the chance to indulge in a little light-hearted frivolity and fun without the usual on-call worries that may have disrupted prior Halloweens or may stand to get in the way of this year's traditional celebration.

The fall scientific meeting marks a new beginning for your medical society. If we are going to continue into the future as a strong voice for public health in Wisconsin, we have to find innovative ways to strengthen our programs and build our alliances.

I hope those who choose to participate in the this special weekend will come away rejuvenated. While the world itself may not always be kinder and gentler, your medical society is learning to be and we need your help and your comments to make sure this and other forums meet both your professional and your personal needs.❖

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Editorial
Publishing reports of important conferences

Thomas C. Meyer, medical editor

Conference report call

Earlier this spring a thoughtful report of a conference held in Milwaukee was submitted.

This caused a fair amount of soul-searching among the Editorial Board. On the one hand, we had all read the report with great interest for it provided each one of us with some information which was new to us. On the other hand, none of us could recall seeing conference reports previously, and we had some concerns over what sort of precedent would be set. So, in good democratic fashion, we took a poll which indicated that most of us felt it should be tried. There was dispute, as there should be, and so we'd like to hear from you.

Elsewhere in this issue, you will find the report. You decide what you think, and if you have time, please write.

The Editorial Board went on to set up an initial set of guidelines that we would follow in reviewing future conference reports. These, too, appear in a separate box and will, in due course, graduate into the "Instructions to Authors." My sense is that the Board will stick fairly closely to these criteria until we have given them a fair trial, i.e., no conference reports have been submitted or so many potential conference reporters scream so loudly that we knuckle under--another trait of democracy!❖

Thomas C. Meyer, MD

The Editorial Board will be pleased to consider publication of brief conference reports. The following ground rules will apply:

1. Only reports of single-topic conferences held in Wisconsin will be considered.
2. The topic of the conference should have interest for a wide group of Wisconsin physicians who would have liked to attend, but the priority was not high enough, e.g., Alzheimer's Disease, AIDS.
3. The author should be the conference chair (or designee).
4. The report should focus primarily on what is "new and important" that can and should be used by the reader.
5. BRIEF is defined as six pages, double-spaced typing. In addition, the author may provide a one-page, double-spaced, background statement as to why the content of the report is important for Wisconsin physicians.
6. The conference brochure should accompany the report. It will not be published.

Soundings

December 7, 1990: The day that would live in infamy

HAVING GONE TO THE garage to gulp down Hycodan from the hidden bottle, I realized the bottle was empty. Who you gonna call? As my mind was hungry for the trip, my fingers did the walking. Having hit on several area pharmacies already, KMart came to mind as next in the rotation. A phone call ensued for a prescription for cough medicine with a fake cough supporting the need. Ten minutes passed. I arrived at the pharmacy. No, not this time. The pharmacist lay in wait. She had called other area pharmacies to find out if I had done the same thing with them. The answer, of course, was affirmative, so she confronted me.

I truly don't know today what tipped her off, but it was a blessing in disguise. A new journey began for me. I called Mike Llufrio at Med Chi's Physician Rehabilitation Program. Mike was very receptive, offered to help, and coaxed me to come for an interview. With the pharmacy's threat of a call to the Drug Enforcement Administration (DEA) hanging over my head, I scheduled an appointment. Never before knowing about the existence of this program or the committee's role, scared and supported by Darvocet, I met with Mike, Tom, and Cathy, counselors of the program. I admitted to my drug problem because I realized that I had no other choice. I agreed to sign the rehabilitation contract, and to go for counseling and Narcotics Anonymous/ Alcoholics Anonymous (NA/AA) meetings.

Ten days later, a Board of Physician Quality Assurance (BPQA) investigator called to inquire about the prescriptions. A meeting with him and a physician at the BPQA offices followed. The BPQA decided to let Med Chi handle my recovery through a memorandum of understanding.

By then therapy sessions were in full swing, and I reluctantly attended AA meetings. At my first meeting, a young recovering alcoholic with tattoos wanted to be my sponsor. Give me a break! I was still in denial, but not having access to opiates, I remained sober.

Eventually, with strong encouragement from my therapist, I started going to AA meetings. Carl, the tough guy with the tattoos, became my sponsor. Opening up myself to him, the AA group members, and the therapist was difficult. Letting go of the anger and fear was even more difficult.

Eventually, catharsis, meditation, therapy, breathing exercises, and enlightenment about co-dependency made my life different. My employer remained solidly behind me throughout, not to forget my wife.

Years went by. Slowly, painfully, and one day at a time I learned how to have a simpler yet better life. After all, life can be and is beautiful without drugs. Each day brings true

happiness knowing that truth. Solid support from my family, the Physician Rehabilitation Program and my monitor, the AA and my sponsor, and my therapist helped catapult me into sunshine out of the darkness of the drug-bound abyss that trapped me.

I pray and thank God every day for this golden second chance. Today I am a better father, husband, doctor, and person.

--Anonymous

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Who can you call?

THE STATEWIDE PHYSICIAN Health Program (SPHP) provides compassionate assistance to Wisconsin physicians suffering from any condition which has the potential to progress to impairment, including: chemical dependency, psychiatric illness, senility, compulsive gambling, behavioral disorders and physical impairment. Consultations are protected by way of confidentiality and immunity under state law.

Any individual concerned that a physician may suffer from impairment may call the State Medical Society (608) 257-6781 or 1-800-362-9080. Staff assigned to receive information consult with the SPHP medical director for guidance. All information remains confidential and is evaluated for accuracy.❖

Soundings
The Old Want

Sheri A. Hunt, MD, Milwaukee

Are they too old to want?
Smelling of baby powder, sour breath
Denture cream and an underneath odor of urine.
Are they too old to remember
What they want?
Let me out of here!
Something like a Wanderguard mutiny.
Hold my hand - pick a hand, any hand.
Can you call my daughter, call my sisters?
Someone stole my housedress.
And my house.
The frail old man's hands
That keep trying to caress the nurses.
The fragile old woman
Who cries for her mother,
The things they ask for last.
I come back the next day.
The day after.
The gasping old fellow
Wanted to know, wanted to know
Grabbed my white coat and needed to know.
His bed is stripped
His things are gone
His name is off the door.
Did someone finally tell him
What he wanted to know?❖

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

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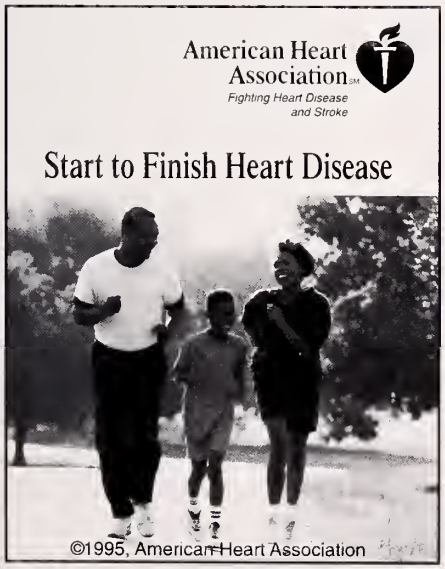

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Percutaneous balloon aortic valvuloplasty in high-risk elderly patients

Richard Park, MD; Donald H. Schmidt, MD; Yoseph Shalev, MD; and Tanvir K. Bajwa, MD, Milwaukee

From 1987 to mid-1994 we performed 16 percutaneous balloon aortic valvuloplasties. All patients (mean age 80 years; 53% female, 47% male) had significant congestive heart failure from aortic valve stenosis; the majority were categorized as New York Heart Association Class IV (shortness of breath at rest). Twelve patients were not surgical candidates; four patients refused surgery. After valvuloplasty, all patients became asymptomatic (NYHA Class I & II), the average preprocedure valvular gradient of 59 mm Hg decreased to 31 mm Hg, and valve area increased from 0.8 cm^2 (0.3 cm^2 - 0.98 cm^2) to 1.3 cm^2 (0.6 cm^2 - 1.44 cm^2). The only complications were two minor groin hematomas (2 patients). Within 6 months, 50% of the patients were symptomatic again; the overall survival rate was 23 months. We conclude that in the proper environment this procedure can be effective and safe— even in high-risk elderly patients. Although symptom improvement is transient, valvuloplasty provides a valuable opportunity to treat intercurrent medical conditions and possibly follow up with surgery.*Wis Med J.1995;94(10):537-541.*

It is readily apparent that the US population is aging. According to one source, there are already 2.5 million persons who are at least 85 years old; by the year 2000 this number will almost double, and there will also be more than 100,000 persons aged 100 years and older.[1] Longer lifespans coupled with continually advancing diagnostic and therapeutic techniques will result in more attention being focused on disease in the elderly (>80 years).

Aortic stenosis (AS) is a relatively common disorder in the elderly—one series showed a rate of 13%.[2] With age the cardiac valves thicken and become more opaque. Aortic stenosis occurs as the result of progressive calcification at the base of the three-leaflet aortic valve. The valve becomes increasingly rigid and obstructs blood flow from the left ventricle to the ascending aorta, leading to symptoms of angina, syncope and, eventually, congestive heart failure.

This disease is responsible for significant morbidity in the elderly population. Until the mid-1980s, the only therapy available was surgical replacement of the valve. But because patients with AS are very sick, the mortality rate was and still remains high—upwards of 30% in octogenarians.[3,4]

In September 1985 Cribier et al performed the first percutaneous balloon aortic valvuloplasty (PBAV) to treat aortic stenosis.[5,6] Subsequent studies and refinements in equipment, technique, and procedure have documented PBAV's ability to improve hemodynamics and provide clinical and symptomatic relief even in high-risk surgical candidates. The initial promise offered by PBAV has not been realized, however, due to restenosis. Within 6 months of their procedure, 50% of patients will once again develop AS, accompanied by symptoms and a grave prognosis.[7,8]

Despite its limitations, indications for PBAV should be determined for several reasons: (1) while aortic valve replacement (AVR) is the treatment of choice for AS, not all patients are suitable candidates for or agree to undergo surgery; (2) for AS patients with associated comorbid conditions that need surgery (eg, cancer), PBAV offers the window needed for treatment; and (3) PBAV palliates symptoms and improves quality (and possibly length) of life.

In an effort to characterize the application of PBAV, we studied retrospectively all patients who underwent the procedure at Sinai Samaritan Medical Center in Milwaukee, Wisconsin from mid-1987 to July 1994.

Methods

Sinai Samaritan Medical Center is

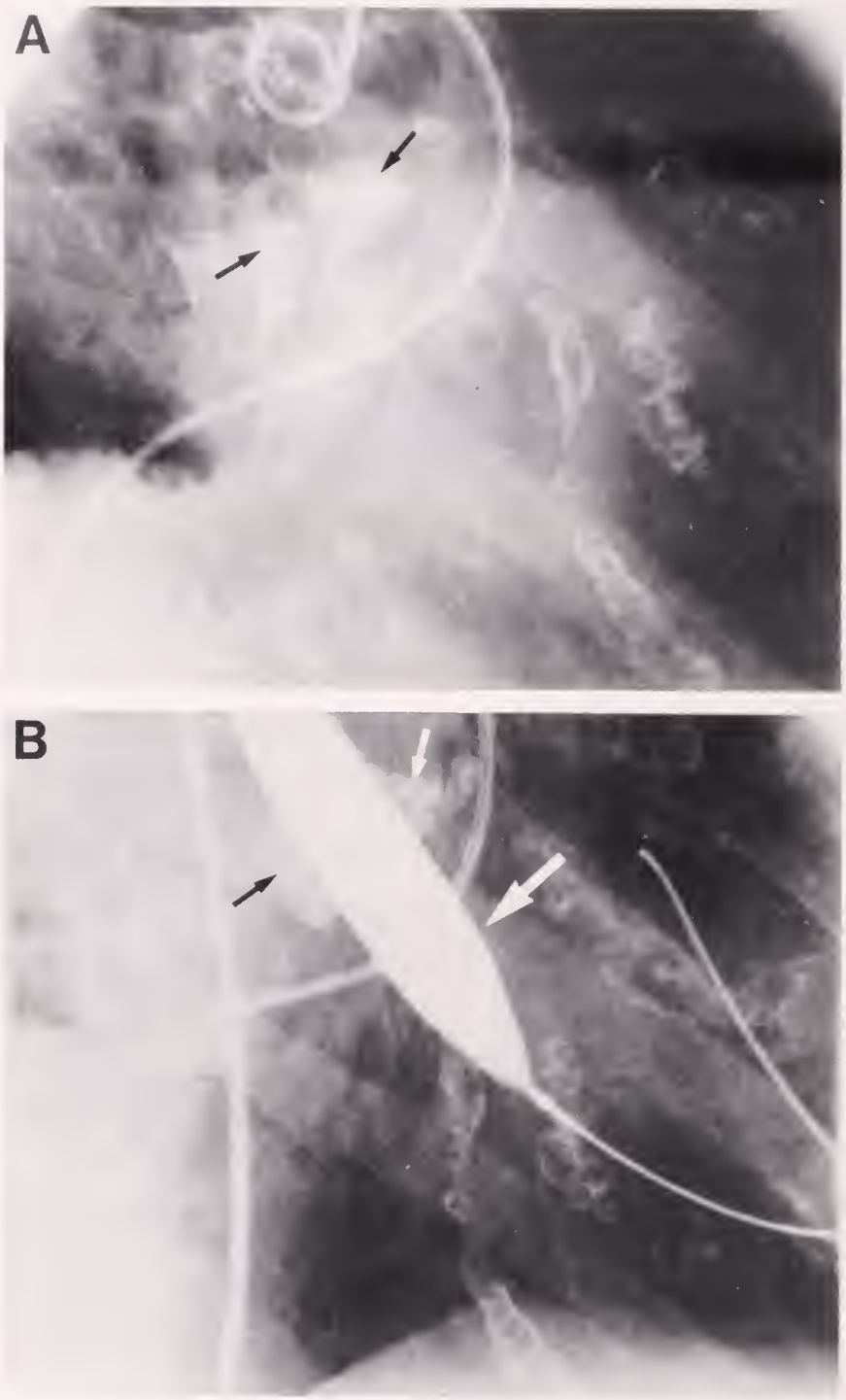

Fig 1.—Balloon valvuloplasty of the aortic valve in an 80-year-old patient. Panel A shows a severe calcification of the aortic valve (arrows). A balloon was advanced to the site via the femoral artery, inflated (Panel B), and was successful in breaking up the blockage and restoring blood flow.

the Milwaukee Clinical Campus of the University of Wisconsin Medical School. The program has 12 adult cardiovascular specialists on staff. To study the application of PBAV, the 16 patients who had the procedure at the hospital during the above-mentioned time period were analyzed (of these 16 patients, two also had associated percutaneous transluminal coronary angioplasty of at least one artery). Their medical records were reviewed for presenting symptoms, age, sex, coronary artery diseases, and New York Heart Association Classification (NYHAC) of their disease. (The NYHAC ranks an individual's severity of heart disease on a I to IV system; I being the mildest, IV being the most severe.)

Pre- and post-PBAV valvular gradients, aortic valvular area, cardiac output and other concomitant procedures were gathered from the hospital's cardiac catheterization registry. The clinical course and final outcome were obtained from outpatient charts, as well as from interviews with patients or close living relatives. The data were examined for the value of PBAV as a palliative procedure and to assess any associated complications.

Results

Of the 16 patients who had PBAV, four had refused aortic valve replacement and the rest had the procedure for palliative measures. The patients' mean age was 80 years and 53% were female and 47% male. The clinical symptoms were angina (40%), syncope (13%) and congestive heart failure (100%), and the majority of patients were categorized as NYHAC IV (shortness of breath at rest).

We used the single-balloon technique, advancing the catheter through the femoral artery to the aortic valve in 14 patients. Two patients had severe peripheral vascular disease: PBAV was carried out via the femoral vein and a transseptal approach in the heart.

After PBAV, the average preprocedure valve gradient of 59mm Hg decreased to 31 mm Hg, the aortic valve area increased from 0.8 cm^2 to 1.3 cm^2, and the average cardiac output went from 4.7 L/min. to 4.4 L/min. The decrease in cardiac output was due to myocardial stunning from the valvuloplasty procedure and myocardial suppression from the contrast material used in the procedure.

The hemodynamic improvement

postprocedure was not dependent on the patient's NYHAC number. The length of time before recurrence of symptoms and survival, however, did show a correlation to their NYHAC number. Symptoms recurred in category II by 18 months postprocedure, category III by 10 months postprocedure, and category IV by 6 months postprocedure.

The typical length of survival by category was: II, 50 months; III, 18 months; and IV, 8 months (overall range 6 mos to 50 mos; mean 23 mos). The only difference age made was that patients who had a recurrence of symptoms within 6 months postprocedure tended to be older.

Analyzing by sex, female patients were 3 years older on average than the male patients. The sex of the patient, however, made no difference in the hemodynamic improvement. Females appeared to have a quicker onset of symptom recurrence. Males survived longer, which may be due to their increased likelihood of having subsequent aortic valve replacement.

Mortality was evaluated at <12 months and >12 months. The patient's age, sex, NYHAC status and conditions of angina, syncope, and congestive heart failure did not make a difference in survival. The changes in gradient and area per body surface area gained were similar in both groups. Although not significantly different, the cardiac output post-PBAV was slightly higher in the >12 month group.

Finally, when single-procedure PBAV patients were compared with the repeat procedure group, the hemodynamic improvement was similar. However, in the repeat procedure group the benefits did not last for more than a month.

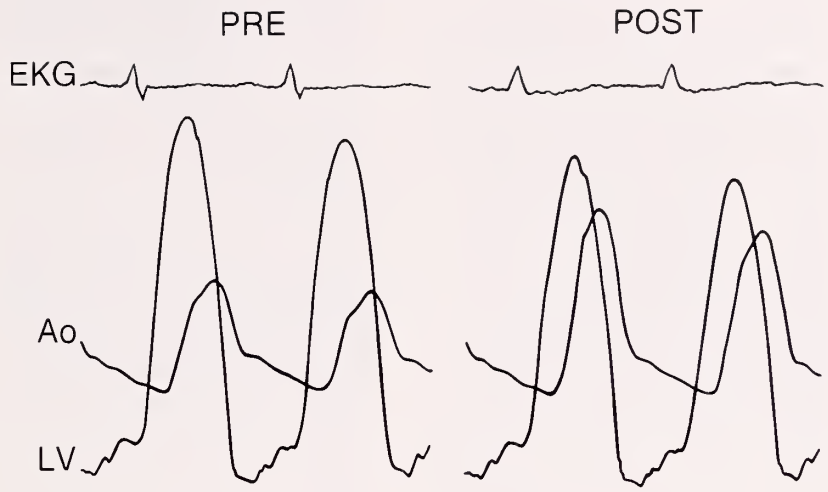

Fig 2.—Pressure gradients pre- and postaortic valvuloplasty. This tracing shows the pressure gradient across the aortic valve pre- and postprocedure in an 80-year-old patient with congestive heart failure. The gradient was reduced from 80 mm Hg to 20 mm Hg, resulting in a marked improvement of symptoms.

Discussion

Due to the dismal outcome of medical therapy in patients with aortic stenosis and congestive heart failure, surgical valve replacement (a procedure proven to have good long-term results) is the standard treatment for patients with aortic stenosis.[9] Surgery is not always a clear-cut choice for these patients, however.

Valve replacement surgery carries with it a relatively high risk, one that, as mentioned, increases with age. Patients with AS tend to be very sick and are not good candidates for any form of therapy, much less major aortic valve surgery. Additionally, some patients may have a comorbid condition that prohibits AVR or requires emergent surgery of its own. However, the risk of mortality in AS patients undergoing major noncardiac surgery is at least 20%.[10,11] Finally, some patients may, for a variety of reasons, refuse surgery.

Percutaneous balloon aortic valvuloplasty offers an alternative to surgery. It is relatively low risk, can be performed in high-risk patients, offers a bridge to surgery for comorbid conditions (as demonstrated by McKay et al[12-14]) relieves symptoms, and buys time for both the patient and physician.

Aortic stenosis in an adult is usually the result of degenerative calcification of the aortic valve, especially at the base of the leaflets. Other less common causes are fusion of commissures and extensive nodular calcification, or combinations thereof.

The authors are affiliated with the University of Wisconsin-Medical School, Milwaukee Clinical Campus, located at The Milwaukee Heart Institute of Sinai Samaritan Medical Center. Dr Park is a cardiology fellow; Dr Schmidt is professor of medicine, and Cardiovascular Disease Section head; Dr Shalev is assistant professor of medicine, and co-director, Cardiac Catheterization Laboratory; Dr Bajwa is associate professor of medicine, and director, Cardiac Catheterization Laboratory and Peripheral Vascular Disease Laboratory. Reprint requests to: Tanvir K. Bajwa, MD, Milwaukee Heart Institute of Sinai Samaritan Medical Center, 960 N Twelfth St, Milwaukee, WI 53233. Copyright 1995 by the State Medical Society of Wisconsin.

Percutaneous balloon aortic valvuloplasty cracks and stretches the leaflets, thereby separating fused commissures and fracturing nodules (see Fig 1).

Because we were selective in using this procedure, our numbers in the study are small. Nevertheless, the study provides experience with which to make comparisons. As seen in other studies, our patients post-PBAV showed a significant improvement in hemodynamic data and a decrease in symptoms.

On average, the pressure gradient decreased by 50% and the aortic valve area per body surface area increased by 100% (see Fig 2). Similarly, the small change in cardiac output seen is comparable to other studies.[15,16] These hemodynamic changes were accompanied by a dramatic decrease in symptoms. For example, one patient with cardiogenic shock due to AS recovered to NYHAC II. Furthermore, hemodynamic improvement was not related to presenting NYHAC or sex.

Even though 11 of the 16 patients had significant coronary atherosclerotic disease and two patients underwent combined PBAV/coronary angioplasty, acute complications were minimal. The most commonly seen complication was a mild increase in aortic insufficiency. We had two patients who had a minor groin hematoma. There were no ischemic events, embolization, dissection, rupture, or mortality.

Our follow-up experience is similar to that of other studies: 50% of patients had a recurrence of symptoms within 6 months, and the average length of survival postprocedure was 23 months.[3,8]

The hemodynamic improvement seen postprocedure was not predictive of a recurrence of symptoms or length of survival. Rather, the patient's age, their NYHAC number and the degree of improvement in cardiac output at PBAV reflected the rate of symptom recurrence and length of survival.

Two of the 16 patients improved dramatically and were able to undergo subsequent aortic valve replacement surgery. Of the three repeat PBAV patients, postprocedure results were similar to the initial results. Unlike the initial procedure, however, the results of the second PBAV were short-lived, as was also seen in a study by Ross.[16-18]

In large studies, younger patients (<65 years) with less calcification and more preprocedure valve area have the best results. In our smaller experience, there were no predictors of immediate success—hemodynamic results were excellent regardless of the patient's age, sex, NYHAC number, preprocedure valve area and gradient, and whether they had angina or syncope.

As seen in the Mansfield Scientific Aortic Valvuloplasty Registry, three variables were shown in our study to be predictors of long-term symptom abatement and survival: age, NYHAC number, and the degree that cardiac output was improved with PBAV.[13,19,20]

In most patients with aortic stenosis, PBAV should be a palliative procedure restricted to those who are poor candidates for surgical aortic valve replacement—possibly due to very advanced age. For critically ill patients with severe aortic stenosis, however, PBAV may be the only therapeutic option available, the goal here being to improve quality of life and, possibly, survival.

In patients with severe left ventricular dysfunction, PBAV can be used as a "bridge to surgery," allowing aortic valve replacement to be performed at a lower risk once the patient's cardiac function improves.

In patients who are good candidates for aortic valve replacement surgery, PBAV has a limited role; it should be considered only when general anesthesia is required for an emergent noncardiac intervention or when the patient has absolutely refused to have surgery.

Treating aortic stenosis in the elderly presents many challenges. These patients are usually quite ill with end-stage disease and are depleted physically and emotionally. But as indicated by our study and others, PBAV, when performed by experienced personnel in a tertiary-care setting, is generally safe (even in high-risk patients), is cheaper than surgery, has minimal complications, and can produce remarkable results—patients have gotten stronger and have gone on to valve surgery.

While restenosis remains the bane of PBAV, that does not mean it should not be offered—a second valvuloplasty can usually be performed.

For physicians, PBAV offers an alternative to surgery, palliates symptoms and enables treatment of other conditions. For patients, it improves their quality of life and may indeed prolong their lives.

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Patient satisfaction with current impotence therapy

Douglas M. Dewire, MD; Eric Todd, MD; and Periann Meyers, RN, Milwaukee

One hundred ninety-eight impotent men were evaluated between July 1993 and June 1994. A "patient goal-directed" approach was used in all cases. Treatment options presented to patients included: oral yohimbine, vacuum constriction devices, penile self-injection therapy, penile prostheses, and testosterone supplementation when clinically indicated. Thirty-two percent of patients declined treatment, and 67% chose nonsurgical therapy. Only two patients (1%) chose penile prostheses. In August 1994, a survey addressing satisfaction with therapy was mailed to all patients, and 99 men (50%) responded. Of the treated respondents, 80% stated that their therapy was "easy to use," and 70% reported that they were "able to have intercourse." Patients prefer nonsurgical impotence therapy, which restores satisfactory sexual function in most men. *Wis Med J.1995; 94(10):542-544.*

Erectile dysfunction affects 15% to 25% of men 65 years of age and older, and accounts for more than 500,000 ambulatory care visits each year.[1] The etiology of impotence may be hormonal, neurologic, vascular, or psycho-genic.[1] Approximately 80% of erectile dysfunction is secondary to organic disease, with arterial or venous abnormalities accounting for up to three fourths of cases.[2,3]

Hormonal causes of impotence include primary or secondary hypogonadism, defined as a decrease in serum testosterone, and hyperprolactinemia. Neurological causes of impotence include lesions affecting the central nervous system, such as cerebrovascular accidents, multiple sclerosis, and spinal cord injury, as well as injuries to the pudendal or cavernous nerves, which may result from pelvic surgery. Diabetes mellitus and alcohol abuse may lead to erectile dysfunction through autonomic neuropathy.

Vascular causes of impotence include both arterial disease, primarily resulting from atherosclerosis, and venogenic impotence, which results from dysfunction of the penile venoocclusive mechanism. Risk factors for vasculogenic impotence include cigarette smoking, hypertension, diabetes mellitus, trauma, pelvic irradiation, hyperlipidemia, and priapism.[4]

Despite the prevalence of erectile dysfunction, many men do not seek treatment because of fear or embarrassment.[5] Compounding the problem is the fact that many physicians are equally uncomfortable with the evaluation and treatment of sexual dysfunction, and therefore avoid discussing these issues with their patients.[6]

Brock and Lue have described the "patient goal-directed approach" to the evaluation and treatment of men complaining of impotence.[7] In this approach, a thorough history and physical are obtained, but further diagnostic testing is minimized. Emphasis is placed on treatment, the goal of which is to provide the patient with an erection suitable for intercourse.

Treatment options available to men with erectile dysfunction have expanded over the past decade. Currently available therapies include oral yohimbine, testosterone supplementation, vacuum constriction devices, penile self-injection therapy, and penile prostheses.[4]

Yohimbine is an alpha-2 adrenergic antagonist which probably works through central nervous system pathways to improve erection in some men.[8-10]

Testosterone supplements are available in oral, injectable, and transdermal patch forms, and are indicated for hypogonadal men who do not have prostate cancer. Transdermal testosterone patches are worn on the scrotum and are changed daily, with peak serum levels occurring about two hours after application of the patch.[11] The most common complaint regarding the transdermal system is difficulty in keeping the patch in place, particularly during vigorous physical activity.

Vacuum constriction devices comprise a hollow cylinder placed over the penis, a suction pump to generate negative pressure within the cylinder, and a constricting rubber ring placed over the erect penis to maintain the erection produced.[12,13]

Self-injection therapy involves injection of vasoactive substances

Table 1.—Age distribution of 198 men presenting with erectile dysfunction, July 1993 through June 1994.

Age	No. of Patients
20-29	4
30-39	21
40-49	31
50-59	65
60-69	56
70-79	19
80+	2

Dr Dewire, Dr Todd, and Meyers are with the Department of Urology at the Medical College of Wisconsin in Milwaukee. Reprint requests to Douglas M. Dewire, MD, Medical College of Wisconsin, Department of Urology, 9200 W Wisconsin Ave, Milwaukee, WI 53226. Copyright 1995 by the State Medical Society of Wisconsin.

directly into the penis, and provides an erection which is physiologically nearer to normal than other treatments.[14,15] Potential side effects of injection therapy include priapism, which occurs in about 3% of patients, and penile fibrosis, which occurs in about 1% of men.

Injectable agents include papaverine, prostaglandin E1, and "Tri-Mix," consisting of papaverine, prostaglandin, and phentolamine. Only prostaglandin has received FDA approval. Tri-Mix results in a more predictable erectile response than papaverine alone, and the cost per dose of $5 makes Tri-Mix about half as expensive as prostaglandin alone.[16]

Because of the potential for complications, penile implants are considered by many to be last resort therapy, although they are quite effective in producing an erection suitable for intercourse.[17,18] Both multicomponent inflatable and malleable, or "semirigid," devices are in use.

This article describes our experience with currently available treatments for erectile dysfunction at the Medical College of Wisconsin.

Methods

Between July 1993 and June 1994, 198 consecutive men were evaluated for erectile dysfunction at the Medical College of Wisconsin. Patient age ranged from 29 to 84 years (Table 1). All patients were offered goal-directed therapy, which included a thorough history and physical examination, basic blood studies including serum testosterone, leutinizing hormone, glucose, and prostate-specific antigen levels.

Then followed discussion of the various treatment options, including oral yohimbine, vacuum constriction devices, self- injection therapy, penile prostheses, and testosterone supplementation when clinically indicated, ie, for men with low serum testosterone levels and no clinical evidence of prostate cancer (normal digital rectal examination and normal prostate-specific antigen).

Table 2.—Treatment choices for 198 men with erectile dysfunction, and 99 survey respondents, treated at the Medical College of Wisconsin, July 1993 through June 1994.

Treatment	No. Total Patients (%)	No. Respondents (%)
Vacuum constriction device	55 (28)	24 (25)
Self-injection therapy	38 (19)	32 (32)
Yohimbine	10 (5)	6 (6)
Testosterone	16 (8)	5 (5)
Penile prosthesis	2 (1)	2 (2)
Combination	14 (7)	11 (11)
No treatment	63 (32)	19 (19)
TOTAL	198 (100%)	99 (100%)

Specific information elicited during the initial visit included the onset and duration of impotence, the presence of nocturnal or spontaneous erections, change in libido, and associated medical problems, as well as the patients thoughts regarding treatment modalities.

All 198 men were surveyed by mail in September 1994, regarding satisfaction with their chosen therapy. Mean duration of follow-up at the time of survey distribution was 5 months (range 2 to 14 months). Questions asked in the survey included: "Is your therapy easy to use?" "Are you able to have intercourse?" and "Is your partner satisfied with your impotence therapy?" Patients who did not respond were contacted by mail 3 weeks after the initial survey in an effort to improve response rates.

Results

Treatment choices for the 198 men evaluated during the study interval, and for the 99 men who completed the survey, are depicted in Table 2. The majority of treated patients chose either a vacuum constriction device (N=56, 28%), or penile self-injection therapy (N=38, 19%). Sixty-four men (32%) chose no therapy. Only 2 men (1%) chose a penile prosthesis as their initial treatment choice during the study interval.

Of the 198 men surveyed in September 1994, 99 (50%) completed the questionnaire. Like the group as a whole, the majority of survey respondents used either a vacuum constriction device (N=24, 25%), or penile self-injection therapy (N=32, 32%).

Overall, 78% of the treated survey respondents noted that their therapy was "easy to use"; 70% of the men stated that they were "able to have intercourse"; and 67% of the respondents believed that their "partners were satisfied with their impotence therapy" (Table 3). The patients' partners themselves were not included in the survey.

Discussion

Our survey response rate was 50%, despite two attempts at patient contact. While nonresponse bias is a legitimate concern in survey studies, the similarities between the treatment choices of the respondents and the overall patient population in our study suggest that the group was fairly sampled. Nonetheless, the possibility that the 99 men who did not respond to the survey could alter the results cannot be denied.

Our experience regarding patient preference and satisfaction with currently available treatments for erectile dysfunction mirrors that reported in the literature. Sidi et al have reported that 68% of men using the vacuum constriction device

are satisfied with their therapy.[12] But pain from the constricting band, or the lack of spontaneity associated with these devices, however, causes about 20% of couples to abandon vacuum devices within a few months.[13] A review of the literature reveals that approximately 80% of patients using penile self-injection therapy are satisfied with their treatment.[14-16]

The fact that only 1% of our patients chose an implant as their initial therapy deserves mention. The introduction of safe, reliable, nonsurgical alternatives to penile prostheses has resulted in a steady decline in the number of penile implant operations performed at our institution over the past 5 years.

Conversely, patient satisfaction with prostheses is expected to increase, since the men undergoing implant surgery have "self-selected" their treatment, and are therefore likely to be motivated toward a favorable impression of the device. Recent reports indicate that over 90% of patients treated with penile implants are satisfied with their results.[17,18]

Althof et al have surveyed partners' satisfaction with impotence treatments, and reported that most women are happy with their mates' erections resulting from vacuum constriction devices and penile self-injection therapy.[19] This important consideration warrants further study.

The modern treatment of erectile dysfunction has evolved toward such nonsurgical techniques as vacuum constriction devices and penile self-injection therapy, which are safe and effective for the majority of patients. A goal-directed approach is recommended, allowing the patient to decide which treatment option is most appealing, thereby increasing the likelihood of a satisfactory outcome.

Table 3.—Overall satisfaction with impotence therapy for 99 survey respondents at the Medical College of Wisconsin, July 1993 through June 1994.

Factor	% Respondents Satisfied			
	Vacuum Device (N=32)	Self-injection (N=24)	Other* (N=22)	Not Treated (N=19)
Therapy is easy to use	72	84	83	—
Able to have intercourse	64	72	73	43
Partner is satisfied with therapy	60	72	68	13

* Includes oral yohimbine, testosterone supplements, penile prostheses, and"combination" therapies.

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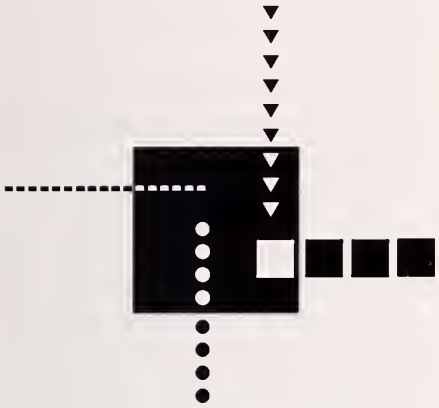

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A reason to hope: Linking dementia research, care and services in the 21st century

Piero Antuono, MD and Jan Beyer, BSN, RN, Milwaukee

RESEARCH, EMPHASIZING the clinical care of Alzheimer's disease patients and families, was the focus of a two-day conference held April 6 and 7, 1995, in Milwaukee, through the patronage of the Helen Bader Foundation, and the University of Wisconsin-Milwaukee Department of Nursing.

This was an important conference for Wisconsin physicians. Firstly, it recognized the significant advances made in our state, both in research, and in the development of innovative approaches for community based services and programs. Secondly, it provided a forum to discuss the numerous advancements in Alzheimer's disease. Many physicians are confronted with the devastation of Alzheimer's disease. Because of its clear morphic presentation, the illness is managed by the general practitioner, as well as by the neurologist, psychiatrist, and geriatrician. With the percentage of the older population increasing, the dementias of old age are becoming more common. Currently, it is estimated that in Wisconsin, 15% of people over age 65, and 50% of those over age 85 have this illness. It has been estimated that up to half of the people residing in nursing homes in our state are afflicted by some form of dementia. There is an increasing sense of need from the practicing clinical community to implement those advances, which over the last 10 years have characterized the field of Alzheimer's disease. Regardless of the specific clinical background of the health care provider, the burden of caring for the patient and their family is time consuming and demanding. Consequently, to facilitate the enhancement of quality of life for the patient and the caregiver, there is a growing need to pull the concerns of health care providers and caregivers into the forefront of Alzheimer's disease research.

Several well known investigators and policy makers participated in the meeting. Dr Robert Katzman (University of San Diego) set the stage by reviewing exciting advancements in the genetics of Alzheimer's disease, and discussing Alzheimer's disease as a chronic disease in which intervention, to be successful, should be attempted in the pre-clinical or latent phase. Possibly, Alzheimer's disease starts up to 30 years before it becomes clinically apparent. Once basic research provides us with a means to stop the disease, the techniques will need to be implemented in individuals at high genetic risk. Dr Khachaturian, (Alzheimer's Disease Program Director of the National Institute of Aging) highlighted the factors which impact upon current national policies concerning Alzheimer's disease. Factors noted included the increased number of Alzheimer disease patients, the chronicity of the disease, and the direct and psychosocial costs of the illness. According to Dr Khachaturian, research advancement needs to be focused in the biological arena, as well as on behavior management and disease prevention. To be successful, good research ideas need to be joined with good people and adequate resources.

Nevertheless, current political/government structures need to be updated if we are to be successful in fighting Alzheimer's disease. Current regulatory standards will need to be modified to study the effects of drugs over an extended period of time to determine if future drug treatments can delay the onset of the illness. Secondly, traditional barriers need to be broken, and strategic alliances need to be formed among the private sector, the federal government, the academic world, and the pharmaceutical and medical industry. It is through these alliances that we will be successful in meeting the challenge of Alzheimer's disease. An example of this innovative approach is represented by a federally funded project (described by Dr Leon Thal, (University of California, San Diego) to set up drug studies using compounds without patent such as Vitamin E and Deprenyl, estrogen, and more recently, anti-inflammatories, such as Prednisone. If these treatment modalities were to be successful, they would be readily available and familiar to all practicing physicians.

The need for standardization and conformity in measures that are used in the clinical setting was discussed by Dr Marshal Folstein (Tufts University), who further detailed the use of the Mini-Mental Status Examination.

One recurrent theme throughout the conference was growing acceptance for the existence of risk factors for Alzheimer's disease. Dr D Evans (Rush Presbyterian University) described the demographics which will result in Alzheimer's disease becoming a significant social problem at the beginning of the next century. Dr Snowdon (University of Kentucky) reviewed his epidemiological work with the religious community of retired School Sisters of Notre Dame in early life predictors of Alzheimer's disease. He discussed how early life language ability may predict the risk of dementia. Whether low attained education level and language ability per se could be a negative risk factor for contracting Alzheimer's disease in old age, or a marker of lower cogni-

tive reserve function, possibly influenced by early life nutrition, is still not clear. The identification of risk factors may be very important to the practicing physician. We could paradoxically find a way to delay the onset of Alzheimer's disease without knowing the cause. If we could simply delay onset of the illness by 5 years, more than 25% of all Alzheimer's cases would not occur.

The clinical utility of current research, involving genetic markers and risk factors was reviewed by Dr Antuono (Medical College of Wisconsin), who interpreted it in light of what may be clinically applicable today. Although genetic testing may be of help for families in whom a specific mutation has been identified, application of genetic markers to the population at large is still not warranted, especially in view of the significant ethical and legal implications that may be generated until treatment is available.

Management of behavior was the focus of the second day. There was significant interest in this aspect of Alzheimer's disease research, which traditionally has not been as developed as has the study of cognitive changes. Management of abnormal behavior is a difficult challenge facing the practicing physician. Ironically, it is the abnormal behavior which health care professionals deal with on a daily basis, that also demands so much of the caregiver. Keynote speakers were Dr Peter Whitehouse (University Hospitals, Cleveland), Cindy Steele, RN, MPH (Johns Hopkins University), and Dr Barry Rovner (Jefferson University). An overview of patients' behavioral symptoms was discussed by Dr Whitehouse, who suggested focusing on the pre-morbid personality of the patient as a predictor of some disturbing behaviors that may surface as the disease advances. While research is providing some understanding of the basic mechanism of depression, aggressive behavior, delusional thinking, and hallucinations, the management, as emphasized by Dr Whitehouse, demands a multi-disciplinary team approach. Included are the physician, the social worker, and the family, frequently the nurse may be the leader in coordinating management of these complex issues with other team members. Dr Rovner stressed that to effectively manage the behaviors, a specific cause for the behavior must be identified. Health care providers need to be aware of predisposing factors that may precipitate abnormal behavior, such as a low frustration threshold which may generate poor impulse control, and mood lability which may generate depression. Abnormal behaviors and agitation may have an origin in medical conditions such as pain, lack of sleep, infection, hyperglycemia, or constipation. Environmental factors including changes in the caregiver or an unfamiliar approach to the patient by the caregiver, or lack of structure, etc., frequently are the key to agitation in the Alzheimer patient.

Management principles were further discussed by Cindy Steele, RN, MPH (Department of Psychiatry, Johns Hopkins University). She stressed that management requires a long-term commitment and that the approach to management should be dynamic, realistic, hopeful, and anticipatory. Successful management of the patient and family requires knowledge of their history of caregiving within the family. This facilitates more successful approaches and links the family to community resources and services which may be available (culture specific) for their individual concerns. By far, this seminar proved to be the most popular and richest in practical applications for those attending the conference.

What may the future be in the current political and economical climate for the fight against Alzheimer's disease and the care of patients? Several speakers attempted to provide a glimpse of the future by discussing the NIA initiatives for research on family caregivers (Dr Marsha Ory, National Institute on Aging), and providing insight on the recent failure of health care reform and the future relationship between the Federal Government and the states in regard to long-term care (William Benson, Assistant Deputy Secretary for Aging). The moral and ethical imperative that the nation has as a whole, to care for elders (Monsignor Fahey, Fordham University), as well as the future possibility of managed care entering the arena of long-term care (William Keane, National Alzheimer Association) was also discussed. This latter topic seemed timely as the current administration is debating Medicare reform.

The two-day conference was enriched by workshops focusing on issues related to Alzheimer's disease such as caregiving, cultural diversity, diagnostic modalities, ethical and sexual concerns, architectural designs, and models of care. Many of these topics showcased projects from Wisconsin, where many new approaches are being developed through the stimulus provided by Helen Bader Foundation grants.

In summary, this conference provided an excellent composite of the latest Alzheimer's disease scientific and clinical research outcomes, as well as applications for practice, especially in the area of behavior management and programs designed for patients with dementia. Linking Dementia Research, Care and Services as the 21st Century approaches, gave the conference attendees a reason to be hopeful about the future.❖

Diagnosis at a glance
Cookie Consultation Corner (CCC)

Physicians: We need your advice. Look over the slides below and make your diagnosis. Please note your answer on the CCC card and return immediately.

Each of these previously healthy two teen-aged males had a lesion in his mouth for approximately 2 weeks. Neither patient smokes or chews tobacco, each feels perfectly well otherwise. The lesions are each solitary, painless and bleed easily. Each patient has the same lesion, what is it?

a. Squamous cell carcinoma
b. Enterovirus infection
c. Herpes simplex infection
d. Pyogenic granuloma

This series is provided courtesy of Gary L. Williams, MD, Department of Pediatrics, University of Wisconsin.

These pictures, along with Dr. Williams' comments will appear in the December *WMJ*, along with a new set of pictures.

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Public health

Breast cancer mortality rates decline for Wisconsin women

Patrick Remington, MD, MPH; Wendy Schell, MS; Kathryn Hoffman, MS; John Fox, MD; and Laura Stephenson-Vine, Madison

Introduction

From 1979 through 1994, over 13,600 Wisconsin women died of breast cancer. In 1995, an estimated 3,800 women will develop breast cancer and 950 will die from the disease.[1] Current research suggests that full implementation of mammography screening guidelines could reduce breast cancer mortality by 30%.[2] Mammography utilization in Wisconsin has increased from an estimated 31,000 mammograms in 1980 to over 500,000 in 1993.[3] This increase in mammography throughout the 1980s should result in a decrease in mortality in the 1990s. The purpose of this paper is to determine if the anticipated decline in mortality from breast cancer has occurred.

Methods

Data on breast cancer deaths among Wisconsin women from 1979-1994 were taken from the Wisconsin Cancer Reporting System, Wisconsin Division of Health. Population estimates for Wisconsin for 1980 and 1990 were obtained from the U.S. Census. Population estimates between 1980 and 1990 were interpolated while those in 1979 and those after 1990 were extrapolated by the Center for Health Statistics, Wisconsin Division of Health. All rate calculations are age-adjusted to the 1990 Wisconsin female population using five-year age intervals.

To estimate trends in breast cancer mortality, we developed a linear regression model using Quattro Pro software. The regression line was determined using age-adjusted mortality data from 1979-1991. Extrapolation of the regression line through 1992-1994 yields predicted mortality rates, assuming the mortality trend is unchanged. We estimated the lives saved in 1992-1994 by taking the difference between the an-

Table 1 - Breast cancer mortality among Wisconsin women, 1979-1994.

Year	Deaths	Crude Rate	Age-Adjusted Rate*
1979	748	31.3	34.3
1980	775	32.3	34.3
1981	795	33.0	35.0
1982	828	34.3	36.3
1983	848	35.2	36.4
1984	843	34.8	35.9
1985	828	34.1	35.0
1986	854	35.1	35.9
1987	848	34.7	35.2
1988	867	35.2	35.4
1989	883	35.6	35.6
1990	922	36.9	36.9
1991	917	36.3	36.1
1992	859	33.7	33.4
1993	910	35.4	34.8
1994	883	34.1	33.4

* Age-adjusted to the 1990 Wisconsin female population.

From the Bureau of Public Health, Wisconsin Division of Health. Dr Remington is chief medical officer for Chronic Disease and Injury Control, Bureau of Public Health, Wisconsin Division of Health. Schell, Hoffman, and Dr. Fox are epidemiologists in the Chronic Disease and Health Promotion Section. Stephenson-Vine is analyst for the Wisconsin Cancer Reporting System, Center for Health Statistics. This work was funded through a cooperative agreement with the Centers for Disease Control (U57/CCU509699-02).Address reprint requests to Patrick Remington, MD, Wisconsin Division of Health, 1414 E. Washington Ave., Room 251, Madison WI, 53703. Copyright 1995 by the State Medical Society of Wisconsin.

nual observed age-adjusted mortality rate and the predicted rate (based on the regression for 1979-1991) and multiplying by the Wisconsin female population for each year.

Results

Age-adjusted breast cancer mortality rates increased about 0.4% per year from 1979 (34.3/100,000) to 1991 (36.1/100,000) (table 1). A linear regression of these data revealed a statistically significant increase in the breast cancer mortality rate during this 12-year period of +0.12 deaths/100,000 per year (95% C.I. +0.02, +0.21) (figure). Assuming a constant population, this increasing rate would lead to three more women dying each year from breast cancer.

From 1991 to 1992, there was a decrease of approximately 7% in the age-adjusted mortality rate (from 36.1 to 33.4/100,000). This lower rate persisted from 1992 to 1994 (see figure and table). If the trend in breast cancer mortality from 1979 to 1991 had continued, we predict that there would have been 44 to 85 more deaths per year than was actually observed during this period (table 2).

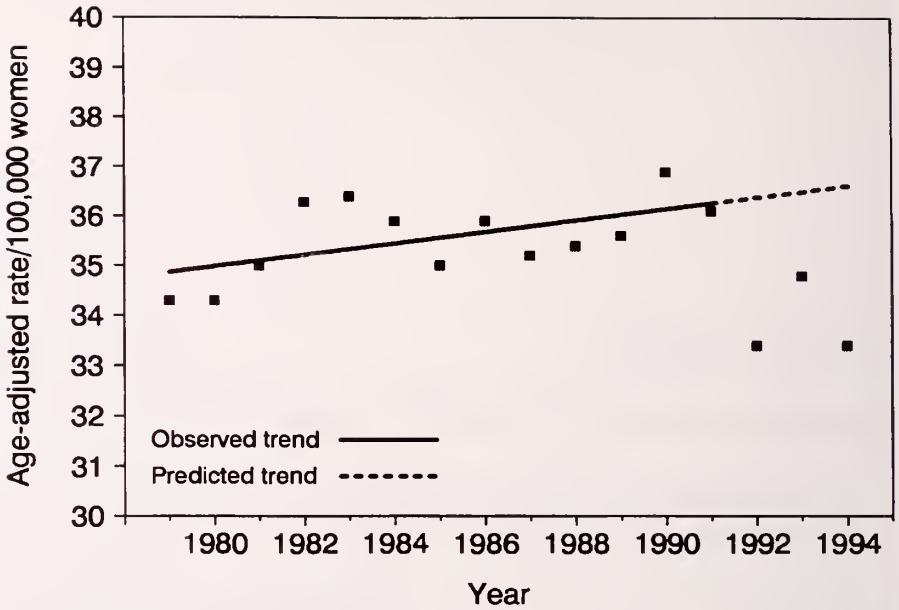

Fig - Trends in breast cancer mortality in Wisconsin, 1979-1994. The line represents a linear regression from 1979-1991.

Table 2 - Difference in observed versus predicted breast cancer death rates and deaths prevented, Wisconsin, 1992-94.

Year	Observed rate*	Predicted rate**	Difference in rates	Deaths prevented***
1992	33.4	36.4	-3.0	77
1993	34.8	36.5	-1.7	44
1994	33.3	36.6	-3.3	85

* Age-adjusted to the 1990 Wisconsin female population.
** Predicted using linear regression of 1979-1991.
*** Difference in observed and predicted rates multiplied by the total Wisconsin female population for particular year.

Discussion

The decline in breast cancer mortality among Wisconsin women has resulted in over 200 fewer deaths between 1992-1994 than would have been expected had the mortality trend continued as it had from 1979-1991. This decline in mortality is expected, given the demonstrated effectiveness of mammography, and the dramatic increase in its use during the past decade.

Rates of screening mammography began to increase in Wisconsin between 1984-1986.[3] The breast cancer mortality rate began declining in Wisconsin in 1992, about seven years after the increasing utilization of mammography. This interval was expected, as mammography results in improved 5- and 10-year survival rates.[4] Given that mammography utilization has continued to increase since 1986[5], further declines in mortality are expected in the future.

Nationwide, breast cancer mortality rates have also declined. Between 1989 and 1992, rates declined by 4.7%--the largest short term decline since 1950.[6] Mortality rates declined among women of all ages, except those women aged 80 and older, who experienced a 1% increase.

The goal for breast cancer mortality in *Healthier People in Wisconsin - A Public Health Agenda for the Year 2000* is to reduce the age-adjusted mortality by 20%, from the rate in 1985. Progress is being made toward reaching this objective, given the recent 5% decline in mortality in 1992-94. However, for this trend to continue, it is imperative that physicians and health care professionals provide annual screening including mammography and physical breast exam to all women patients age 50-75. Equally important is the development of strategies to reach women who have never been screened or who are not being routinely screened.

Acknowledgements
The authors thank Jerri Linn Phillips and Robert Adler, Center for Health Statistics for their technical assistance.

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The Wisconsin Women's Cancer Control Program: 1993-1995

Gale D. Johnson, MPA; Laurie A. Garrett, MSPH; and Ruth M. Benzie, RN, Madison

Introduction

The Division of Health established the Wisconsin Women's Cancer Control Program in 1993, as part of the Section of Chronic Disease Prevention and Health Promotion in the Bureau of Public Health.[1] This program is funded by the Centers for Disease Control and Prevention (CDC), as part of the 1993 National Breast and Cervical Cancer Early Detection Program. The goal of the Wisconsin Women's Cancer Control Program is to reduce mortality from breast and cervical cancer by increasing the number of low income and under-served women who are routinely screened, and by improving the quality of screening, referral, and follow-up. This report summarizes the screening experience from the beginning of the program to Aug 31, 1995.

Johnson is director, Garrett is data manager, and Benzie service delivery coordinator, of the Wisconsin Women's Cancer Control Program, Chronic Disease and Health Promotion Section, Bureau of Public Health, Wisconsin Division of Health. This work was funded through a cooperative agreement with the Centers for Disease Control (U57/CCU509699-02). Address reprint requests to Patrick Remington, MD, Wisconsin Division of Health, 1414 E. Washington Ave., Room. 251, Madison WI, 53703. Copyright 1995 State Medical Society of Wisconsin.

Background

In September, 1993, the CDC awarded the Division of Health a 5-year, $12.5 million grant to develop and implement the comprehensive breast and cervical control program. Wisconsin is now one of 35 states and nine American Indian tribes providing breast and cervical screening services to eligible women.

The primary population targeted by the Wisconsin Women's Cancer Control Program is low-income women (i.e., annual household income at or below 200% of the Federal Poverty Guidelines) who are age 50 or older and who are uninsured or underinsured. Special emphasis has been placed on reaching black, Asian, Hispanic and Native American women as well as women living in rural areas.

Significant economic, geographic, and knowledge barriers prevent many older women, especially those with low incomes, those residing in rural areas, and those from various racial and ethnic communities from accessing mammo-graphy and Pap screening services. These women do not benefit from early diagnosis and treatment.

In July, 1994, the Wisconsin Women's Cancer Control Program released a "Request for Applications" for 1-year capacity building grants. The intent of the local capacity building grants was to build upon existing coalitions, community groups and organizations to strengthen and expand breast and cervical cancer screening services throughout Wisconsin. In response to the requests, capacity building grants were awarded to more than 60 agencies representing local public health departments, family planning agencies, YWCAs and Indian tribes.

Local coordination

Unlike many of the other state breast and cervical programs, the Wisconsin Women's Cancer Control Program is decentralized. Sixty-eight "local coordinators" carry out the intent of the capacity building grants in the 72 counties around the state. These individuals are the backbone of the program. They recruit service providers, do outreach and education and are case managers for

women enrolled in the Wisconsin Women's Cancer Control Program.

Screening Services

The Wisconsin Women's Cancer Control Program began screening eligible women June 1, 1994. There are 390 physicians, physician clinics, hospitals, rural health clinics, laboratories, radiologists, mammography facilities, pathologists, tribal health clinics, and nurse practioners who have contracted with the program to provide breast and cervical screening services at approximately 600 sites around the state. Pap screening services are provided at more than 300 sites, mammography at more than 100, and at least 50 sites provide both types of screening services (figure). With this type of reception from health care providers, eligible women are able to go to the provider of their choice for screening services.

For the period June 1, 1994 through Aug 31, 1995, 2,931 women from 69 counties were screened through the Wisconsin Women's Cancer Control Program (table). Most (84%) women in the program are 50 years of age and older. Most (92%) have received a mammogram. Five of these screenings resulted in a diagnosis of breast cancer. Black women made up 24% (687) of the women who received mammograms statewide, representing only 2.6% of the state's female population.

Of the 2,931 women, 938 (32%) have received pap tests. Of these, 70 (7%) are minorities.

Statewide collaboration

Following the lead of the National Breast and Cervical Cancer Early Detection Program, collaboration with other organizations is a strong theme for the Wisconsin Women's Cancer Control Program. Workgroups have been established for each component of the program with representatives from the American Cancer Society, Planned

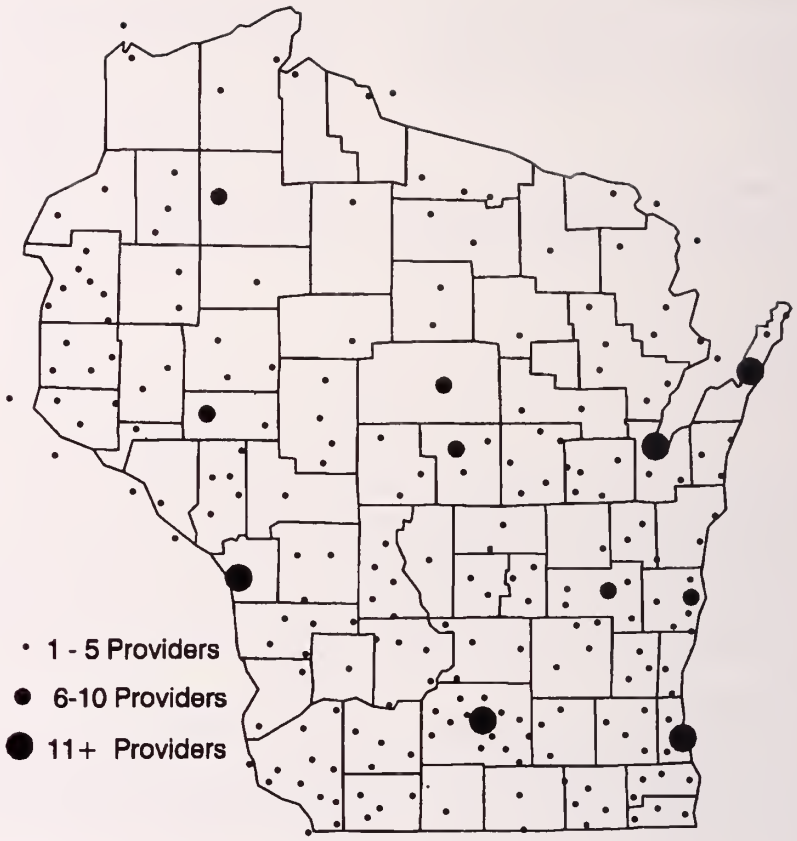

Fig - Wisconsin Women's Cancer Control Program service providers, as of Aug 31, 1995.

Table - Age and race distribution of women screened as part of the Wisconsin Women's Cancer Control Program, June 1, 1994 through August 31, 1995.

Population	Mammograms		Pap Smears	
	No.	Percent*	No.	Percent*
Race				
African American	687	24%	7	1%
Asian	38	1%	2	0%
Native American	80	3%	21	2%
Hispanic	124	4%	14	1%
White	1723	61%	868	93%
Other	170	6%	26	3%
Age				
<40	2	0%	2	0%
40-49	442	16%	151	16%
50-64	1348	50%	608	66%
>=65	904	34%	163	18%
All women	2696	100%	938	100%

* Percent of total known.
Asian includes Pacific Islander.
Native American Includes Eskimo.

Parenthood, the Black Nurses Association, Great Lakes Inter-Tribal Council, local health departments and various community organizations with an interest in breast and cervical cancer.

Continuing with the theme of collaboration, the program is working on various activities with the Cancer Information Service, Wisconsin Cancer Council, Wisconsin Women's Cancer Network, and the University of Wisconsin Comprehensive Cancer Center.

Work was recently completed on the radio and television public service announcements aimed primarily at rural white women. The *"Mammography-You Can Live With It"* campaign begins this fall. Similar campaigns are planned for black, Asian, Hispanic and Native American women in the coming year.

Conclusions

The Wisconsin Women's Cancer Control Program began its third year Oct 1. One of the most important components for the next year is tracking, follow-up and re-screening services to assure that every woman who has been screened through the program is encouraged to return on a regular schedule for breast and cervical cancer screening.

Acknowledgments

We appreciate the graphics support of April Stankiewicz, and comments and suggestions of Patrick Remington, MD, and Susan Wood, Wisconsin Division of Health.

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Establishing a Women's Cancer Control Program using a multi-county consortium

Faye Gohre, RN, BSN; Cherie Meyer, RN, BSN; Linda McFarlin, RN, BSN, MA; Barbara Theis, RN, BSN; Beverly Muhlenbeck, RN, BSN, MPH; and Gale Johnson, MPA

Introduction

The current uncertainties of health care reform and limited funding for public health programs have challenged local health departments to seek innovative strategies to ensure meeting the health needs of their communities. One example of this is the use of the multi-county consortium model, a partnership of several local health departments designed to pool resources to provide specialized services within a regional area. This consortium model was adopted by several local health departments as part of the Wisconsin Women's Cancer Control Program, to implement county-wide breast and cervical cancer outreach and screening programs.

Background

The Wisconsin Women's Cancer Control Program is a statewide screening program funded by Centers for Disease Control and Prevention (CDC) from 1993 to 1998. The goal of this program is to reduce breast and cervical cancer mortality by increasing the availability of cancer screening to high risk populations through existing community-based providers.

In the first year of the program, grants were provided to community-based non-profit organizations who serve economically disadvantaged populations. These grants were designed to develop local partnerships and infrastructure to provide breast and cervical cancer screening services to underserved women, particularly women who are older, low-income, or racial and ethnic minorities. Wisconsin chose a "decentralized" approach to this program, to encourage local communities to design programs which would best meet their particular needs. This has resulted in locally controlled programs managed by 68 local program coordinators who have recruited over 390 providers to provide screening services at more than 600 sites throughout Wisconsin.

Multi-County Consortium

Rather than develop single county programs, Adams, Juneau, and Sauk counties decided to combine resources to develop a multi-county consortium to apply for this grant. This decision was based on practical and economic concerns as well as past experiences with partnerships. These three local health departments meet together monthly to

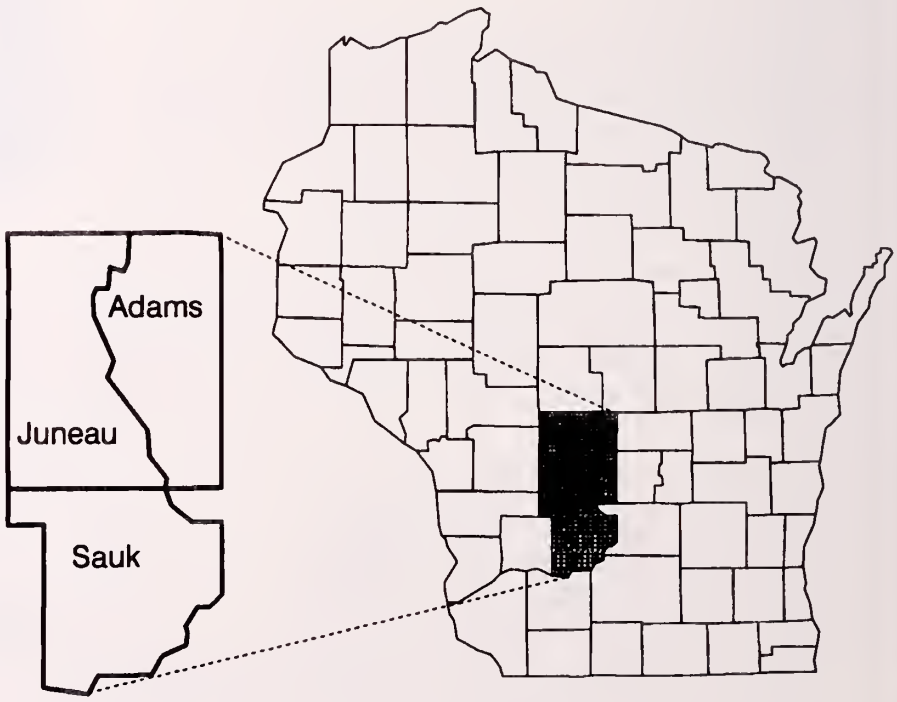

Fig - A multi-county consortium for breast and cervical cancer control in Wisconsin, 1995.

Gohre is a Chronic Disease Specialist, Bureau of Public Health, Southern Regional Office; Meyer is the Program Coordinator for the Adams, Sauk and Juneau Women's Cancer Control Program Consortium; McFarlin is the Adams County Public Health Director; Theis is the Juneau County Public Health Director; Muhlenbeck is the Sauk County Public Health Director; and Johnson is Director of the Cancer Control Program, Chronic Disease and Health Promotion Section, Bureau of Public Health, Wisconsin Division of Health. This work was funded through a cooperative agreement with the Centers for Disease Control (U57/CCU509699-02). Address reprint requests to Patrick Remington, MD, Wisconsin Division of Health, 1414 E. Washington Ave., Room. 167, Madison WI, 53703. Copyright 1995 State Medical Society of Wisconsin.

discuss mutual issues and problems, and have a long history of collaboration and joint problem solving. The three health directors had also had successful experiences working together on public health projects in maternal and child and environmental health issues.

Factors leading to the success of their collaboration include mutual respect and trust in each other's judgement, and an atmosphere in which they feel free to openly discuss any problems which arise. All agreed that pooling efforts would maximize overall capacity by allowing one person to specialize and become an "expert" in a program. This would allow a program coordinator to concentrate on expanding this particular program in a regional area without the competing everyday challenges which occur within small local health departments. If each health department applied separately, funding would only allow staff time several hours per week to manage the program in each county.

The three counties are in close proximity and share some similar characteristics. Adams and Juneau counties use some of the same health care providers and all three counties are predominantly rural. The county health directors rotate responsibility for taking the lead as fiscal agent on shared projects and participated in the hiring of the shared program coordinator.

In the first year, the program coordinator developed a good provider base in each county and built an extensive outreach program to reach targeted women within each county. In addition, a "Kick-Off" event was held, with influential celebrities, including First Lady Sue Ann Thompson, State Health Officer Ann Haney, and local citizens and politicians. This increased interest in and support for the program in the community.

The three county health department provide program oversight, including determining program priorities, budget expenditures, and program evaluation. Initially, the program coordinator met frequently with the health directors. As experience was gained, meetings were scheduled every other month to discuss program activities, screening, and plans. Problems are discussed as they arise. Individual task forces of volunteers and professionals have been developed in each county, and are comprised of individuals committed to program goals and assisting in outreach efforts.

Comment

The consortium model resulted in more effective and efficient mobilization of their communities to broadly expand the program within their area. The program coordinator was identified as the contact person, which allowed her enhanced visibility to increase awareness and community commitment to the program. Designating one person to coordinate the program in this region resulted in increased access to services, since the program coordinator was successful in obtaining the cooperation of every mammography and Pap test provider in Adams and Juneau counties, and all but one provider in Sauk County. The program coordinator determines participant eligibility and coordinates tracking and follow-up with the providers. She also helps to resolve provider problems as they arise, such as billing, and reimbursement.

Several problems with the consortium model have been identified. First, only one person for the three counties is well trained in the program specifics; it would be difficult for someone else to pick up on program activities if the current coordinator were absent. Another concern is that the coordinator has additional public health responsibilities, so some shifting from one activity to another as immediate public health concerns arise and take precedence, does occur. Limiting added responsibilities to a few specific areas, rather than all public health programs in general, helps to minimize this problem. Other potential problems with a consortium could include lack of cooperation, inability to reach consensus about program priorities, or competition among members.

In summary, three counties in Wisconsin developed an innovative strategy to provide public health services for breast and cervical cancer in their communities using a multi-county consortium model. This model pooled resources and increased the ability to provide specialized services within a regional area. This consortium model is especially well suited for projects with a limited time frame or specialized focus. This model permits health departments in rural areas to expand coverage beyond the essential core functions of public health, and to work with new community partners in health promotion and chronic disease prevention.

Health care providers interested in more information about the Wisconsin Women's Cancer Control Program can call their local health department and speak with the local coordinator, or call the Women's Cancer Control Program, Division of Health office, at 608-266-8311.

Acknowledgments

We appreciate the comments and suggestions of Richard Yoast, PhD, Patrick Remington, MD, and Susan Wood.❖

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A bold survivor: Wisconsin's first lady leads way to increasing breast cancer awareness

Genie Campbell, special to *WMJ*

Wisconsin's First Lady Sue Ann Thompson is not shy about discussing the new title randomly bestowed upon her--that of breast-cancer survivor.

It's been almost a year since a routine mammogram detected the small cancerous growth that necessitated three surgeries within days of one another, leaving her feeling so low, she said, that "even the floor was looking up."

But late this summer Thompson was given a clean bill of health. She's returned to teaching sixth-graders, is far more conscientious about adhering to a low-fat diet and, like so many of us, attempts, not always successfully, to exercise every day.

Yet, although she's happy to be back in familiar routines, she readily admits that having had breast cancer has not only changed her life forever, but underlined the importance for her, as first lady of Wisconsin, to strongly advocate the need for increased breast-cancer awareness.

"It doesn't stop; there's never a point where it's all over," said Thompson, interviewed by phone. Even if the cancer is eradicated, the daily confrontation with immortality is not, she said, nor the feeling that "what you do today may have a definite impact" on your life tomorrow. "That's when I really decided that it was extremely important to speak out."

Toward that end, Thompson, 54, has participated in a variety of cancer-awareness activities throughout the state during the past six months, including taking part in a American Cancer Society benefit relay run for breast-cancer survivors in Oconomowoc and presenting the keynote address last spring for the Women's Cancer Update in Madison. Ironically, when first asked to speak, months in advance of the event, she hadn't yet been diagnosed with cancer.

"There is a real value in having a person with a well-known name promote awareness of a particular problem because more people are likely to pay attention," said Mary Kausch, coordinator of the Women's Center at Meriter Hospital-Capitol, a sponsor of the annual conference. "It's happened before with breast cancer--Happy Rockefeller, Betty Ford and Nancy Reagan to name three." But because of her prominent state ties, Thompson hits even closer to home.

Earlier this month she took part in a breast-cancer awareness rally held on the steps of the state Capitol. In November, Thompson will speak at the "Reach To Recovery" program in Wisconsin Rapids, and as head of the National Governors Association Spouses organization, she intends to promote, state-by-state, breast cancer awareness nationwide. "It is an issue that has had a profound effect on my life and one that many of the first ladies feel very strongly about," she said.

Because her mother died at the age of 70 from breast cancer, Thompson was not surprised by the diagnosis last fall. Even so, her initial reaction was a fairly typical one of shock and disbelief.

"I've had mammograms every year for the past six or seven. Every time I went in I experienced fear and trepidation and so, when they told me I had breast cancer, it wasn't totally unexpected. But I don't think you're ever really ready for it. It's as if someone stomps on your stomach. The air is knocked right out of you. My heart, of course, just sank. Everything abruptly comes to a halt, nothing really seems that important any more. Your life is threatened; your health is threatened.

"But after thinking about it, I realized I had to be positive, get a hold of myself and the situation," she continued. "By gaining some control over my health and my body, I also gained confidence that I could beat it. By doing everything possible to be positive and maintain a daily routine, a certain momentum took over, helping me to move forward. In becoming aware of my total health picture, I knew exactly what I could do and I relied on a wonderful, encouraging medical staff (University

First Lady Sue Ann Thompson has inspired Wisconsin women with her courageous and frank discussion of her own experience with breast cancer.

Campbell is a Madison-based, free-lance writer and former features editor of the Wisconsin State Journal.

Traveling display--Sue Ann Thompson and Wendy L. Schell, epidemiologist for the Wisconsin Women's Cancer Control Program, are pictured with a traveling display used to give women information about the state's early screening program. The display has been used across the state and at the Wisconsin State Fair.

Women's health advocates--(from left) Cherie Meyer, RN, program coordinator for the Adams, Sauk and Juneau Women's Cancer Control Program; SMS President Marcia J.S. Richards, MD; First Lady Sue Ann Thompson; Mildred Leigh-Gold, program coordinator for the Milwaukee Health Department's breast cancer screening initiative; and then-Division of Health Director Ann Haney are leaders in the state who have made a real difference in helping Wisconsin women learn about cancer screening opportunities and programs.

Hospital in Madison) to do the things that I couldn't. The rest was up to God as to what would happen next. I really felt that way."

On Nov. 29 of last year, Thompson underwent a lumpectomy to remove cancerous breast tissue. Upon the recommendation of her physicians, she returned Dec. 5 for an oophorectomy as a precautionary measure to eliminate the risk of ovarian cancer. A week later, she had hernia surgery, to remove a blockage that had developed as a side effect from the previous operation.

Still, on Jan 4, Thompson stood beside her husband, Gov Tommy Thompson, as he was sworn into his third term of office. And in March, after recuperating from 6 weeks of radiation therapy, she enthusiastically returned to teaching at Kendall Elementary School near the Thompsons' family home in Elroy.

"Cancer is a dread word that no one wants to hear, but I believe with a positive attitude, a caring environment and the availability of the latest in research technology it can be overcome," Thompson said in a press release at that time.

The state's first lady believes that a cure for breast cancer is possible and the more women speak out on the issue, the sooner that cure will be found.

In the meantime, "the only cure we have right now is early detection: self-exams and mammograms. It's absolutely necessary for women to take control of their health; it's the best way of overcoming breast cancer. I think that it's a shame that with the number of women dying every year (from breast cancer) more hasn't been done," she said.

Thompson is urging all adult women, even those in their 20s to do regular breast self-examinations and get a mammogram. According to the Cancer Reporting System of the Wisconsin Center for Health Statistics, the detection of breast cancer before the cancer spread beyond the breast increased from 49% of cases

in 1981 to 65% of cases in 1993, the latest year for which statistics are available. The agency attributes this improved detection rate to the increased use of mammograms.

"I definitely think women in their 20s should have at least a base-line mammogram, another one in their 30s, again in their early 40s and by the age of 45, begin having them every year. Too many women fall between the cracks because they haven't been examined early enough. And yes, if insurance doesn't cover the cost of a mammogram, I recommend that women pay for it. Your life is more important, "she said, adding that there are some options available for inadequately insured women.*

With the aid of federal grant money, the Wisconsin Women's Cancer Control Program is offering free health services including breast and pelvic exams, mammograms and pap tests to women 50 and older or even younger, if they are considered to be at high risk for certain cancers. These women must also fall below certain income guidelines.

Victims of breast cancer include more than women undergoing treatment. "We always talk about the person. But breast cancer has a traumatic impact on spouses and the entire family. They, too, find themselves in a state of confusion, wondering what they can do to help. My family was very supportive," said Thompson.

State Chronic Disease Epidemiologist and Chief Medical Officer for the Wisconsin Division of Health Patrick Remington, MD, MPH, and Barbara Nehls-Lowe, of the Wisconsin Women's Cancer Control Program, joined those offering appreciation to Wisconsin's first lady for her work in increasing awareness of the need for breast cancer screening.

With a history of breast-cancer in the family--Thompson's mother had her first mastectomy at the age of 36--the first lady is equally concerned that her two daughters, the oldest of whom is 25, have mammograms within the very near future.

No woman can afford to be complacent, she believes.

"Eighty percent of all breast cancer in women does not show any family history for the disease. We have to be alert."

** Thompson's recommendations do not reflect current scientific guidelines. Women should always consult with physicians regarding individual histories.*❖

Video, support group are partners in survival

Genie Campbell, special to *WMJ*

When a member of Bosom Buddies, a Madison-based breast cancer support group was killed recently in an automobile accident, some members grew very pensive.

"I read where she was an avid gardener," said one at a subsequent meeting. "So am I, but we never talked about it."

So right then and there, the approximately 20 women in attendance, bonded together by a diagnosis that instantly changed their lives forever, took turns talking about their vocations and passions in life.

It felt good; it made them realize, no one can take life for granted. "We'd laugh and say, at least you know what you're going to die from," said another member. "But even that isn't true."

Founded in Aug 1987, Bosom Buddies is not unlike many support groups that disseminate valuable information and offer emotional

support for breast-cancer patients and survivors. But unlike those sponsored by hospitals and clinics that focus primarily on treatment options and statistics, Bosom Buddies has one and only one agenda - to be there for one another, to share tips and strategies for combating breast cancer and all the emotional baggage that goes with it. Meetings are held monthly. There is no formalized structure, no officers, no set dues. Every month a hat is passed to raise enough money to take care of expenses, primarily the publication of a monthly newsletter.

While almost every member is or was a member of a support group organized by the medical institution where they received surgery or treatment, it is Bosom Buddies that is most likely to sustain them over time, from a patient to a survivor.

Serving as inspiration and facilitator for the group is founding member Cheryl Murray, 48, who has been free of breast cancer for 9 years.

"So many people were there for me, this is my way of helping others," said Murray, who initiated Bosom Buddies at a time when there were many cancer support groups, but few dealing specifically with breast cancer. "You know where somebody is and how they're feeling," she said. Though professionals can relay valuable information, until you've had breast cancer, you can't possible know what it's like to go through it, she added.

Although offered meeting space at area clinics, Murray and three cofounders took turns meeting in each other's homes because "we agreed in the beginning that we didn't want to have a setting that reminded us of cancer or cancer treatment. When the group outgrew private living rooms, it moved to a church.

Of the four original members, Murray is the only one who is still alive. Watching two die within weeks of one another was extremely hard for the lone survivor, because the four had grown very close to one another. Today, early detection has significantly boosted survival rates for women with breast cancer. But death remains a constant, occasional visitor to the group.

"It's very difficult (when a member dies), especially a new members," said Murray. "It got to the point where we weren't talking about it at meetings. But we have to support each other in this as well as healing."

To that end, members of Bosom Buddies let the tears flow freely, but, at the same time, laugh at themselves and the comical moments cancer does induce and only those with cancer can appreciate. Meetings are always concluded with a joke, sometimes cancer-related.

As women feel more comfortable talking publicly about their experiences with breast cancer, avenues for support are increasing, even within the privacy of one's home. A breast-cancer discussion group now exists on the Internet with subscribers from more than 23 countries.

"It's like a support group because you hear from these people all the time; you get emotionally involved with people you've never met," said a Bosom Buddies member who monthly relates information she gleans from the Internet to the rest of the group. Everyone, from breast-cancer survivors and patients, including one man, to caring physicians who volunteer their time and professional opinions, regularly log on.

Timing is very important, believe many women.

Reaching women from that shocking moment of diagnosis is the intent of a new 50-minute film released in October called "Partners in Survival." The first project from Oughta Be Productions, a non-profit company based in Madison, the video is the brainchild of a group of concerned people, including Judith Perkins, a professional facilitator, and Lorraine Meisner, professor of preventive medicine and human oncology at the UW Medical School. Though no one in the initial group planning this project had ever been diagnosed with breast cancer, they still recognized the need for an instant "cheering section, a group of voices whose sole purpose was to offer their empathy and collective wisdom."

"The video is an experience; it is not educational nor entertainment," said Perkins. "The medical establishment does a wonderful job today in the treatment of breast cancer. A lot of strides have been made. But it doesn't have the time to really address the roller-coaster emotions this kind of catastrophic illness puts on a person.

Perkins and others who worked on this project envision the medical community offering "Partners In Survival" to newly diagnosed breast-cancer patients, during the peak period of shock, fear and disbelief.

"Partners In Survival" means not only is a woman a partner with her physician but also a partner with all the other women who have gone through the experience of breast cancer." said Perkins. "They are there for you. Though I was heavily involved in the making of this video, every time I look at it, I'm moved. These women (breast-cancer survivors) are so beautiful in their hearts."

"We're hoping it will accomplish what we set out to do, to tell a woman that having breast cancer is not a death sentence, that she will find the courage to survive and plan for the future and that she may even find her life better after she has gone through it.

For more information about "Partners In Survival," retailing for about $20, call (608) 274-7074, or write Oughta Be Productions, PO Box 46092, Madison, WI 53744.

For information about Bosom Buddies, telephone (608) 244-3062 or (608) 831-1841.

Medicare update: SMS summarizes proposed 1996 changes to Medicare Part B

Federal Register July 26, 1995

1. HCFA is proposing to apply budget neutrality adjustments to the conversion factors rather than the relative value units (RVUs).

2. HCFA is proposing to bundle hydration therapy I.V. infusion (90780 and 90871) when performed at the same time as chemotherapy I.V. infusion (96410, 96412, 96414). Payment would continue to be separate for the saline solution and chemotherapy drug.

3. HCFA is proposing to change the status indicator for CPT-4 codes 90825 (evaluation of psychiatric records and reports) and 90887 (family counseling services) to "B" to show that payment for these codes is bundled into the payment for another service, and separate payment would not be allowed.

4. HCFA is proposing to assign a "B" status indicator to CPT-4 codes 92352-92358, and 92371 to show that payment for these codes is bundled into the payment for the spectacles.

5. For x-rays and EKGs taken in the emergency room, HCFA is proposing to:

   - allow Medicare carriers to pay separately for only one interpretation of an EKG or x-ray procedure furnished in the ER. However, there should be provision for an additional interpretation under unusual circumstances such as a questionable finding for which the physician performing the initial interpretation believes another physician's expertise is needed.

   - include a requirement with the radiology section of the carriers' manual that the professional component of a diagnostic procedure furnished to a beneficiary in a hospital includes an interpretation and report for inclusion in the beneficiary's medical record maintained by the hospital.

   - distinguish between an "interpretation and report" of an x-ray or an EKG procedure and a "review" of the procedure. An interpretation and report is separately payable by the carrier. A review of the findings of these procedures without a written report, does not meet the conditions for separate payment of the service since the review is already included in the ER visit payment.

   - instruct the carriers in the case of multiple billings to adopt the following procedure:

   - End the policy of considering physician specialty to be the prime consideration in determining which interpretation and report to pay regardless of when the service is performed.

   - Pay for the interpretation and report that directly contributed to the diagnosis and treatment of the patient.

   - Pay for the interpretation billed by the cardiologist or radiologist if the interpretation of the procedure is performed contemporaneously with the diagnosis and treatment of the beneficiary (This may be a verbal report conveyed to the treating physician that will be written in a report at a later time).

6. HCFA is proposing to extend the site-of-service payment reduction to services provided in an Ambulatory Surgery Center (ASC). In addition, HCFA proposes to add approximately 150 ASC approved CPT-4 codes to the site-of-service list.

7. For the services of teaching physicians, some of the more notable changes HCFA has proposed are:

   - Change the attending physician criteria to render it more flexible in terms of the individual teaching physician. An individual physician may serve as the responsible physician for a particular service while ensuring that a physician is present during the "key" portion of each service payable by the carrier.

   - For surgery or dangerous/complex procedures, the teaching physician must be **present** during all critical portions of the procedure, and must be **immediately available** to furnish

Continued on next page

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services during the entire service/procedure. The physical presence requirement would not be met when the presence of the teaching physician is required in two places for concurrent major surgeries. The teaching physician's presence in individual procedures must be documented in the operative note showing beginning and ending times. For minor procedures such as endoscopies, the teaching physician must be present during the viewing in order to receive reimbursement. A discussion of the findings with the resident would not be sufficient. However, with a diagnostic procedure such as an x-ray, the teaching physician would not be expected to be present during the performance of the test, and could bill for an interpretation by reviewing the film with the resident (or by performing an independent interpretation).

- In the case of evaluation and management services (visits, consults), the appropriate payment level billed must reflect the extent and complexity of the service, if the service was fully furnished by the teaching physician. For example, if the medical decision-making in an individual service is highly complex for an inexperienced resident, but straightforward to the teaching physician, payment is made at the lower payment level reflecting the involvement of the teaching physician. HCFA will allow the teaching physician to decide if he/she needs to provide hands-on care in addition to the services of the resident. However, in the case of hospital inpatient and outpatient evaluation and management services, the teaching physician must be present during the key portion of the visit.

- The presence of the physician during the service or procedure must be documented in the medical record. This eliminates the requirement that the attending physician personally examine the patient, and leaves the decision to the teaching physician as to whether he/she should perform an exam in addition to

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the resident's exam based on medical and risk management consideration, rather than Medicare payment rules.

- Services of teaching physicians that involve the supervision of residents in the care of patients are payable under the physician fee schedule only if the teaching physician is present during the key portion of the service. If a physician is engaged in such activities as discussions of the patient's treatment with a resident but is not present during any portion of the session with the patient, HCFA believes that the supervisory service furnished is a teaching service as distinguished from a physician service to the patient.

- With respect to psychiatric services (including evaluation and management services) furnished under an approved psychiatric GME program, the teaching physician would be considered to be "present" (during each visit for which payment is sought) as long as the teaching physician observes the visit through visual devices (one-way mirror or video equipment) and meets with the patient after the visit.

8. HCFA is proposing to eliminate HCPCS codes M0005-M0008 and H5300 for physical therapy and occupational therapy services. Physical and occupation therapy services would be billed under the codes found in the Physical Medicine section of CPT-4 (97010-97799). HCFA feels the HCPCS codes are too nonspecific.

9. HCFA is proposing to enunciate a national policy on transportation in connection with furnishing diagnostic tests. (HCPCS codes R0070-R0075 and R0076.) Because no national policy has existed, it was within each Medicare carriers discretion to determine when payment for the transportation of diagnostic equipment should be made.

   Medicare carriers would continue to pay for the transportation of x-ray and EKG equipment in the following areas:

   - Medicare carriers would continue to make transportation payments under HCPCS codes R0070-R0075 in connection with portable x-ray procedures if approved suppliers furnish the services described below:

     - Skeletal films involving arms and legs, pelvis, vertebral column, and skull.

     - Chest films that don't involve the use of contrast media (except routine screening procedures and tests in connection with routine physical exams).

     - Abdominal films that do not involve the use of contrast media.

   - Medicare would make transportation payments under HCPCS code R0076 in connection with standard EKG procedures if the approved portable x-ray supplier furnishes the service described by CPT-4 code 93005 (or 93000, if the interpretation is billed with the tracing).

   - Medicare would make transportation payments under HCPCS R0076 in connection with standard EKG procedures (93005) furnished by an Independent Physiological Lab (IPL) when:

     - the IPL meets applicable State and local licensure laws;
     - the EKG is ordered by a referring physician; and
     - Medicare determines the service is reasonable and necessary.

10. HCFA is proposing to establish RVUs for maxillofacial prosthetic services (codes 21079-21087, G0020 and G0021). Currently, these codes have been priced manually by each Medicare carrier.

    The work RVUs that HCFA is proposing to use were developed by the American Academy of Maxillofacial Prosthetics (work RVUs were not listed in this issue). The practice expense and malpractice expense RVUs were imputed by HCFA based on practice cost shares provided by the American Association of Oral and Maxillofacial Surgeons. The practice and malpractice expense RVUs proposed are 54.7 and 4.4, respectively.

    HCFA is proposing a 90 day postoperative period for all codes except 21085 and G0020. These two codes will be assigned 10 day postoperative periods.

    Codes 21079-21087, G0020 and G0021 should be used only if the physician actually designs and prepares the prosthesis. Physicians that design and prepare the prosthesis and bill codes 21079-21087, G0020 and G0021 will not be paid sepa-

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rately for the prosthesis itself (L8610-L8618). The "L" codes can only be billed by an outside lab that has prepared the prosthesis.

Codes 21079-21087, G0020 and G0021 are currently on the site-of-service reduction list because they are predominantly office-based procedures. This will continue for 1996 services as well.

11. HCFA is proposing to expand the definition of "diagnostic" mammography to include:

    - a patient with a personal history of breast disease, and
    - a patient who is not experiencing signs and symptoms of breast disease but who has a personal history of biopsy-proven breast disease.

    HCFA will not change the definition of "screening" mammography so that patients with a personal history of breast cancer can be considered candidates for the screening exam, if they and their physician decide that it is appropriate.

12. HCFA is proposing to calculate the Medicare Volume Performance Standard (MVPS) for 1996 (and all future years) based on estimates of the average volume and intensity (VI) growth specific to each specialty category, i.e., surgical services, primary care services, etc. To date, HCFA has used an estimate of the average annual percentage growth in the VI of all physician services. This means that targets for surgery, nonsurgery and primary care are based on trends profession-wide, rather than surgery being based on surgical trends, primary care based on primary care trends, and so on.

    HCFA is proposing this regulatory change now to address immediate problems in the fee schedule, however it is their intention to move toward the development of a legislative proposal to implement a single MVPS and conversion factor for all Medicare physician fee schedule services.

13. HCFA is proposing to apply the medical direction payment policy to a procedure involving both the physician and an (one) anesthetist.

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Currently, Medicare will only reimburse the physician in cases where he/she is medically directing one anesthetist. This change is slated for implementation on **Jan 1, 1998**.

14. The technical amendments signed Oct 31, 1994, requires the Secretary to develop methodology for a resource-based system for determining practice expense (PE) RVUs for each physician service. Currently, PE RVUs are derived from historical allowed charge data.

    The contract for developing this system was awarded by HCFA on March 31, 1995, to Abt Associates. The contract outlined the following schedule of completion of certain activities:

    - data collection and delivery completed by **March 1996**
    - report on analysis by **Sept 1996**
    - proposed rule in *Federal Register,* **March 1997**
    - final rule in *Federal Register,* **Nov 1997**
    - implementation **Jan 1, 1998**

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15. HCFA is welcoming comments on a possible framework for a Medicare primary care case management option either under current regulations or through a demonstration project. They have been reviewing some of the following approaches:

    - Apply primary care case management methods (gatekeeper) currently used by private payers and Medicaid programs to the Medicare fee-for-service system.
    - Under the physician fee schedule, construct fee arrangements with primary care physicians that would promote greater use of case management.
    - Undertake demonstrations of primary care case management that involve beneficiary enrollment or election and different approaches for a primary care option.

    HCFA's intent at this time is to solicit information, recommendations, and suggestions from the public on how they might apply primary care case management to the Medicare fee-for-service system. HCFA is particularly interested in the following:

    - Which physicians, providers, or other health care professionals should be designated as case managers?
    - Which types of patients would benefit from case management?
    - What evidence is there that case management is valuable to patients other than those with chronic illnesses or acute episodes?
    - Should Medicare pay for case management services and how should they be paid?❖

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A word from WIPRO
Decreasing the rate of bilateral cardiac catheterization

Jay A. Gold, MD, JD, MPH, Madison

A NUMBER OF WIPRO's improvement projects have been suggested to us by the work of other peer review organizations. For example in 1993, IPRO (the Island--for Long Island--Peer Review Organization), WIPRO's counterpart in New York State, discovered that a number of New York medical centers were performing bilateral cardiac catheterizations at a very high rate. That is, it appeared that frequently, right heart catheterizations were being performed routinely when left heart catheterizations were done.

Such a practice raises two issues about the appropriateness of care. First, without a specific indication for right heart catheterization, the clinical yield of the procedure is extremely low. The most rigorous prospective study of bilateral catheterization found that case management was changed for only 1.5% of patients who received right heart catheterization without a listed indication. The study concluded, "In patients undergoing left-sided catheterization for evaluation of chest pain, the yield of important diagnostic information from right sided catheterization is low and the cost is high."[1]

The second issue is cost. IPRO calculated that the marginal charges for right heart catheterization (that is, total charges for bilateral catheterization minus total charges for catheterizing the left heart) were $346 physician reimbursement and $700 hospital cost, which comes to a total of $1,046 per case. Given the number of such procedures performed, there would appear to be a great potential for savings with minimal detriment to patients.

IPRO worked with New York hospitals, with some success, to lower these rates. We at WIPRO felt that this project would be worth pursuing in Wisconsin as well, since the considerably variation New York found in rates of performance of the procedure was likely to exist here as well. We first put together a study group consisting of four cardiologists, a research physician, and several quality/utilization specialists. The study group agreed that right heart catheterizations ought not to be performed without specific indications (see table). At their behest, we reviewed claims data for the calendar years 1992-93 for all cardiac catheterizations performed on Medicare patients. After eliminating cases where diagnostic codes revealed accepted indications for right heart catheterization, we found an enormous range of variation in hospital rates, from 0% to almost 100%. Furthermore, of 9,544 cardiac catheterizations performed during that period, 3,860 - 40.4%, were bilateral; however, of the 40 Wisconsin hospitals that do cardiac catheterizations, only 13 had a bilateral catheterization rate of over 33%. We invited these 13 hospitals to collaborate with us in this project, and 7 of them accepted our invitation.

A WIPRO clinical coordinator made presentations to cardiologists at the collaborating hospitals, reviewing the data and the study group recommendations. Discussion was instructive: for example, at one hospital we were informed that right heart catheterization was performed routinely in order to "establish a baseline," a rationale without warrant in the literature. At this writing, most hospitals already have submitted improvement plans; such plans concentrated on further education of the cardiology staff in this area. One hospital declined to submit a formal plan, though the cardiologists there did agree with us that it was essential to "consider carefully on a case by case basis the potential contribution of right heart catheterization data." (Note in the table that the clinical judgment of an experienced cardiologist will qualify as an indication.)

Consensus criteria for right heart catheterization
• Congenital heart disease • Valvular heart disease • Pulmonary hypertension • COPD • Congestive heart disease • Other (per physician judgment)

Since our initial data analysis, WIPRO has been able to examine 1994 data, and we find a significant decrease in the statewide rate for bilateral catheterization, a decrease which certainly is independent of WIPRO's project in this area. Recent New York data tell a similar tale. Apparently, there is a growing consensus that right heart catheterization should not be done routinely. Whole some of the hospitals whose rates had been high in

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A word from WIPRO is not reviewed by the *WMJ* Editorial Board. Dr Gold is WIPRO's Principal Clinical Coordinator. He also serves as Assistant Clinical Professor of Preventive Medicine and Bioethics at the Medical College of Wisconsin, and as Senior Lecturer in Preventive Medicine at the University of Wisconsin, Madison. Reprint requests to Jay A. Gold, MD, JD, MPH, WIPRO, 2909 Landmark Place, Madison, WI 53713. Copyright 1995 by the State Medical Society of Wisconsin.

WIPRO's initial analysis show a considerable decrease, others continue to show a large number of bilateral catheterizations. It is our hope that the focusing of attention on this issue will lead to a universal acceptance of the principle that right heart catheterizations should be done only when indicated. Examination of more recent data, when available, will provide evidence as to our success.

Reference

1. Hill J, Miranda A, Keim S, Decker M, Gonzalez J, lambert C. Value of right-sided cardiac catheterization for evaluation of coronary artery disease. *Am J Cardiology* 1990;65:590-593.❖

Life insurance claims? Here's what to do

Michael J. Dolan, CLU,ChFC, Madison

When there's a death in the family, life insurance can provide almost immediate cash to meet immediate needs. Before you can get that cash, however, you have to file a claim. Here's what to do:

- Call your insurance agent. He or she can help you fill out any necessary forms, and act as an intermediary with the insurance company.
- If you don't have an insurance agent, or don't know who the deceased's agent was, you can deal directly with the insurance company. Call or write to its nearest office to ask what procedure should be followed.
- Secure certified copies of the death certificate from the funeral director; one copy must be submitted with each life insurance claim.
- Submit the death certificate together with the claim form and either the policy itself, if it is requested, or its number.

Once the claim is submitted, you should receive a settlement in fairly short order. You may received a lump sum or installments if the insured elected a settlement option. The insurance company will pay the proceeds as instructed.

Typical settlement options available are:

- an **interest income** option, which permits the company to hold the proceeds and pay out interest on those proceeds, either for a specified period or for your lifetime. The interest paid will be based on a rate stated in the policy. Some insurance companies will put the money in a money market mutual fund paying current market rates.
- **specific income provisions,** either with income for a specified period or with income of specified amounts. In this option, payouts of both principal and interest are made on a predetermined schedule and at a predetermined rate.
- a **life income** option, similar to an annuity, in which you are guaranteed income for life. The income will be based on your age and sex at the time of the policyowner's death. If you live longer than the insurance company expects, based on mortality tables, you'll come out ahead because you'll collect more than the life insurance proceeds. If you die early, however, a substantial portion of those proceeds may be forfeited.
- a **lump sum,** which gives you the option of using what's needed for immediate purposes (paying funeral expenses, final debts, and current living costs) while investing the rest. Lump sum payments, if you have any investment skill, offer the most flexibility.

Michael J. Dolan, CLU,ChFC

If you need help, or are uncertain about what to do, consult your insurance agent. ❖

Dolan is vice president and chief operating officer of SMS Insurance Services and a member of the National Association of Life Underwriters.

Special section on firearm injuries

Call to the community II: We called; you responded

Richard G. Roberts, MD, JD, immediate past president, and Lynn Sherman, SMS policy analyst

THIS ISSUE OF *WMJ* features a report by the Milwaukee Academy of Medicine, "Public Health Strategies to Reduce Firearm Injures and Death in Milwaukee County." The report emphasizes that firearm injuries should be considered a public health problem, not just a criminal issue. The Academy highlights that a comprehensive approach must address the three factors needed for a firearm injury: the host (e.g., person using the gun); the agent (e.g., weapon, ammunition), and the environment (e.g., poverty, substance intoxication). The report challenges the citizens of Wisconsin to develop leadership and community involvement in order to remedy the problem.

We can take justifiable pride in pointing to our response to this challenge: CHILD SAFE. One year after the launching of CHILD SAFE, it seems appropriate to reflect for a moment on its impact. Close to 500 physicians in more than 30 Wisconsin communities have joined the effort to reduce childhood firearm injuries. From Cumberland to Kenosha and from Waukesha to Wood County, physicians, hospitals, health departments, law enforcement agencies, school districts and their respective staffs have raised funds and public awareness in their communities.

Firearm safety materials -- including nearly 25,000 CHILD SAFE brochures, thousands of gun safety check lists and posters and locally produced messages on home safety -- have educated Wisconsin residents about the safe use and storage of firearms. Radio and television messages blanketed the state during last fall's media campaign. The CHILD SAFE public service announcement, aired on 131 stations during October and November, played 4,448 times. More than 12,000 trigger locks and 10,000 trigger lock coupons were distributed. Throughout the year CHILD SAFE activities were highlighted in more than 100 newspaper articles. Evening TV news stories in all major market areas of the state provided additional attention to the program.

The success of this SMS project, and the continued requests to participate from county medical societies and others, stimulated the establishment of a non-profit, tax exempt foundation, CHILD SAFE, Inc. Start up funds have been provided by another $100,000 grant contributed generously by Blue Cross Blue Shield United of Wisconsin. The new foundation will permit tax deductible contributions and participation by a wider range of individuals and groups, without posing a financial burden to the SMS. The medical society continues to be very involved in the new foundation through member leadership on the foundation board and SMS staff assistance. A new media campaign is planned for this fall -- look for it and use it as an opportunity to raise the issue with patients.

Your commitment and leadership made CHILD SAFE possible and successful. As the participation and programming of CHILD SAFE broadens through its new foundation, we will have opportunities to continue to answer the call to reach out to our communities. Review the October 1994 issue of *WMJ*, which was dedicated to the issue of firearm safety and announced the birth of CHILD SAFE. The issue contains enduring and excellent advice on how to discuss firearm safety with patients and on how to get communities involved. While CHILD SAFE has helped us take an important first step, the Milwaukee Academy of Medicine report reminds us that we still have a long journey ahead of us.❖

PUBLIC HEALTH STRATEGIES
To Reduce Firearm Injuries and Deaths In Milwaukee County

Executive Summary

This report was prepared by Lara Pratt, MPH,
and the following members of the Public Health Committee
of the Milwaukee Academy of Medicine:

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Katherine Dillig, M.D.
Edmund Duthie, M.D.
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A Report From the Public Health Committee
of The Milwaukee Academy of Medicine

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MEDICINE
1886

About This Report

Firearm deaths, which include homicides, suicides, and unintentional gunshot wounds, have recently become the leading cause of injury death in Milwaukee County. Firearm injuries have a tremendous impact on the health of Milwaukee County residents as well as the financial health of this community.

Public Health Strategies to Reduce Firearm Injuries and Deaths in Milwaukee County was prepared by the Public Health Committee of the Milwaukee Academy of Medicine to examine the following areas:

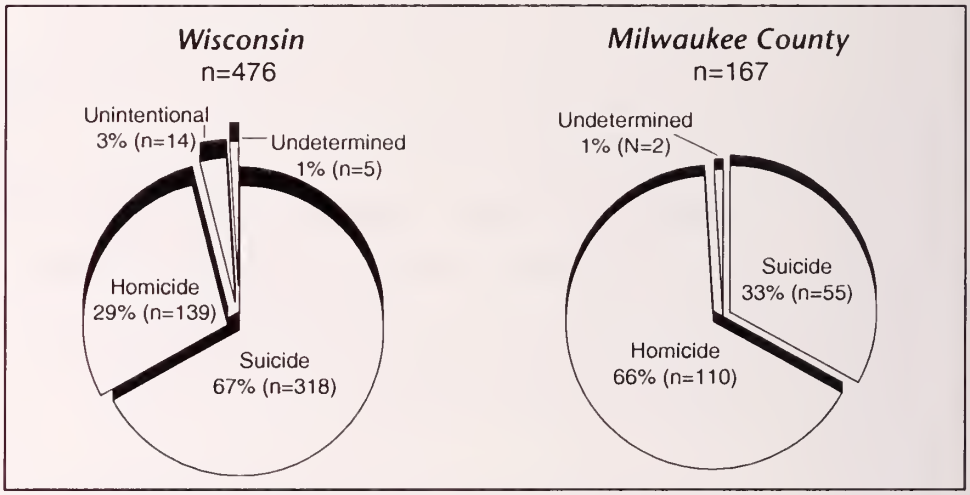
- Firearm morbidity and mortality in Milwaukee County;
- Individual, environmental, and firearm characteristics that are associated with or contribute to firearm injuries;
- The application of public health strategies to address the problem of firearm injuries; and
- Recommendations for building a comprehensive approach to address this problem.

Impact of Firearms on Health

In Wisconsin, an average of 476 people were killed with firearms per year between 1990 and 1993. Thirty-five percent (n=167) of these deaths occurred in Milwaukee County.[1] As shown in Figure 1, firearm suicides were the most common type of firearm death in Wisconsin (67%), whereas firearm homicides accounted for the greatest proportion of firearm deaths in Milwaukee County (66%).[1,2]

Firearm Deaths in Wisconsin, and Milwaukee County, 1990-1993—Average per year

Figure 1



Firearm Suicides

- Males, ages 70 to 79, are the population with the highest suicide rates in Milwaukee County.[2]
- The overall rate of suicide among white teens in Milwaukee County is declining while the rate among teens of color is increasing.[2]
- African-American and Hispanic teens comprised 100% of *all* teenage suicides (n=5) inMilwaukee County in 1993. Each died from self-inflicted gunshot wounds.[2]

Firearm Homicides

- Eighty-one percent of all firearm homicides in Milwaukee County occurred in the City of Milwaukee.[2]
- Most commonly, firearm homicides are committed in the context of an argument by people who know each other and have been drinking alcohol or using drugs.

- African-American males are the population with the highest firearm homicide rate in Milwaukee County.[2]
- Recent evidence suggests that socio-economic status, rather than race/ethnicity, explains differences in homicide rates in the various populations.[3]

Unintentional Firearm Deaths

- Unintentional firearm deaths represent a small percentage of all firearm deaths on national, state, and local levels. Examples of unintentional firearm deaths include deaths that occur while playing with, cleaning, and/or carrying a firearm.
- There were 53 unintentional firearm deaths in Wisconsin between 1990 and 1993.[1]
- In Milwaukee County, there were two unintentional firearm deaths between 1990 and 1993.[2]

Non-Fatal Firearm Injuries

- Applying national estimates of the 1:7 ratio of fatal to non-fatal firearm injuries, Milwaukee County yields approximately 1,170 non-fatal firearm injuries per year.[4]
- Froedtert Memorial Lutheran Hospital's Spinal Cord Injury Center treated 268 patients for firearm injuries that resulted in various degrees of paralysis between 1989 and 1993.[5]
- 398 children were treated for gunshot wounds in the emergency department of Children's Hospital of Wisconsin between 1989 and 1992. Forty-seven percent (n=187) were admitted to the hospital.[6]

Financial Impact of Firearms

- The direct treatment costs for 268 gunshot wound victims at Froedtert Memorial Lutheran Hospital's Spinal Cord Injury Center exceeded $6.3 million.[5]
- Nearly $3 million was spent to treat child gunshot wound victims at Children's Hospital of Wisconsin between 1989 and 1993.[6]
- Through taxes allocated to Medicaid, Wisconsin residents paid the costs of treating the majority of firearm victims between 1989 and

1993. For example, 89% of the 268 gunshot wound victims treated at the Spinal Cord Injury Center were supported solely by public programs, which do not completely reimburse hospitals for their costs. The Spinal Cord Injury Center was reimbursed for 24% of the costs incurred to treat firearm victims.[5]

Preventing Firearm Injuries: The Public Health Model

Traditionally, society has addressed firearm violence through the criminal justice system, which intends to deter firearm-related crimes by taking punitive measures after they have been committed. However, the promise of punishment is unlikely to be given prior thought by an adolescent who impulsively shoots an acquaintance during an argument, by a suicidal person, or by those who unintentionally shoot themselves while handling a firearm. Through an emphasis on prevention rather than response, public health strategies offer a useful framework for addressing firearm morbidity and mortality.

From a public health perspective, health problems result from the interaction between an agent/vehicle, host, and environment, each of which is defined in Table 1.

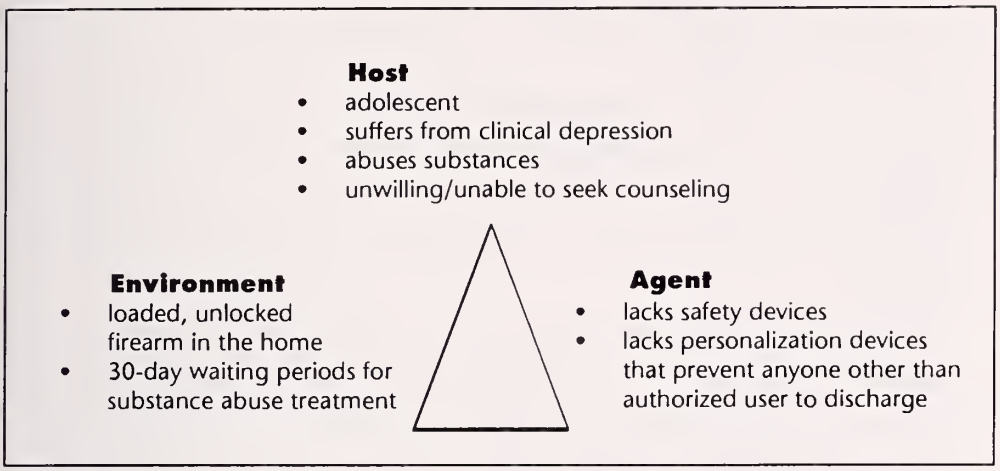
Definition of Agent/ Vehicle, Host, and Environment

Table 1

Agent/Vehicle	Host	Environment
Agent: Thermal, mechanical, or kinetic energy that causes an injury **Vehicle:** Element through which the agent is transported	Element on which the agent has its effect	Context in which host and agent/ vehicle meet; describes the immediate context such as an argument, as well as the social, political and economic context.
Example: Mechanical energy transported through a .25 caliber firearms	**Example:** Adolescent sustains a gunshot wound	**Examples:** Argument; home or community in which firearms are readily available.

Each of these three elements consists of characteristics that make it more or less conducive to injury. For example, host characteristics can include physical properties such as a pre-existing health condition or psychosocial characteristics such as economic status. Figure 2 illustrates the application of the public health model to a firearm suicide.

Figure 2



Application of Agent/Vehicle, Host, Environment Model to a Firearm Suicide

The goal of public health interventions is to affect the agent/vehicle, host, and environment in order to decrease the likelihood they will interact to cause disease or injury. Although all firearm deaths result from gunshot wounds, regardless of their intent, the people and contexts in which firearms are discharged vary greatly. Accordingly, strategies to prevent these incidents must be multiple and common threads between them must be identified when possible. The following discussion outlines several strategies for preventing firearm injuries in Milwaukee County. Please refer to the full report, *Public Health Strategies to Reduce Firearm Injuries and Deaths in Milwaukee County* for a complete description of these strategies, their application, their strengths and limitations, and their implications for Milwaukee County.

Host Strategies

Strategies aimed at hosts incorporate either education to alter behaviors that contribute to one's risk of firearm injury or treatment to alleviate a condition, such as clinical depression, that places an individual at high risk for a firearm injury.

Education—Health education efforts designed to reduce firearm injuries are delivered through a variety of mediums ranging from mass media campaigns to individual counseling. In Milwaukee County, there are a variety of educational efforts underway, including a violence prevention curricula delivered in the schools, suicide awareness training, and violence awareness campaigns and activities sponsored by local churches and community groups. The effectiveness of these strategies in reducing firearm injuries has not been evaluated to date.

Treatment—Treating individuals for conditions such as mental illnesses and/or substance abuse is an important host strategy because these conditions considerably increase an individual's risk of firearm injury. Sixty-two percent of 1990 firearm homicide victims in Milwaukee had positive blood alcohol tests, while 25% had cocaine in their blood streams.[7] Alcohol and substance use are strongly associated with firearm suicides in other communities; however, there is no data to demonstrate this relationship in Milwaukee County.

In Milwaukee County, the effectiveness of substance abuse treatment programs may be limited by difficulties in identifying people who need treatment, particularly adolescents and elderly patients, by 30-day waiting periods and by state and local budget cuts for publicly supported centers that threaten the funding of long-term treatment programs.

Environmental Strategies

There are numerous and diverse environmental factors that contribute to firearm injuries and deaths: physical characteristics of the environment such as overcrowded living conditions, political characteristics such as legal access to firearms, and economic characteristics such as poverty. Consequently, the implementation of numerous and diverse environmental strategies should reduce firearm injuries and deaths.

The quantity and types of firearms in the environment do not directly cause firearm morbidity and mortality, rather they significantly contribute to the risk of firearm injuries. According to local data, 10.5% to 35.7% of respondents in Shorewood, West Allis, Milwaukee, Franklin, and Wauwatosa reported that they kept a firearm in their home.[8] In Milwaukee and Shorewood, there are efforts currently underway intended to reduce the quantity and types of firearms available.

Handgun Ban—Milwaukee and Shorewood residents voted on a referendum in November 1994 that proposed to ban the possession of most handguns. Other communities have implemented similar bans, but few have been evaluated. Restrictive handgun licensing in the District of Columbia resulted in an initial, short-term reduction in firearm deaths.[9]

Gun Buy-Back Programs—The Milwaukee Police Department is currently sponsoring a voluntary gun buy-back program in which people receive $25 in exchange for their handgun, the type of firearm that causes the majority of firearm injuries. Evaluation data from a similar program in Seattle reported no significant difference in firearm-related crimes, injuries, or deaths between the year preceding the program and the six months after it.[10]

Limit Access to Firearms—Strategies to limit people's access to firearms can range from reducing the number of people who are federally-licensed firearm dealers to increasing the restrictions on those who can purchase and own firearms. As of October 1993, there were 6,100 federally-licensed firearm dealers in Wisconsin, 583 of whom were registered in Milwaukee County.[11] National, state, and local laws could increase criteria for obtaining federal firearm licenses. Currently before the Senate Judiciary Committee, Section 303 of the "Handgun Control and Violence Prevention Act of 1994" would increase the fee for obtaining a federal firearm license from $30 to between $200 and $3,000 per year. Presently, there is no data to suggest this change would impact the availability of firearms or health.

Because firearm homicides are overwhelmingly concentrated in areas of Milwaukee with few economic and social resources, efforts to improve community and individual economic status must be included in strategies to reduce firearm morbidity and mortality. The inner city banking campaign of the Milwaukee Inner City Congregations Allied for Hope (MICAH) resulted in the Accord on the Principles to End Economic Apartheid in Milwaukee and a commitment of $488 million in business and home loans for reinvestment in the central city. These efforts, as well as others (job training, improved access to mental health services and other human service programs), could have an important overall impact not only on the health and well-being of Milwaukee residents, but also on firearm injuries specifically.

Agent/ Vehicle Strategies

Strategies that target modification of firearms have the broadest potential impact on fatal and non-fatal firearm injuries because they bypass issues associated with intent, decrease reliance on individual behavior change, and may take effect more quickly than many environmental changes.

Characteristics of firearms used in firearm injuries must be determined in order to focus agent/vehicle strategies effectively. However, data are limited due to inconsistent reporting. One study determined that in Milwaukee County during 1992 and 1993, an average of 77% of firearm deaths were caused by handguns. In handgun homicides, .25 caliber firearms were the weapons most often used, while .22 caliber firearms were most often used in handgun suicides. The Raven was the most commonly identified handgun involved in 1990 Milwaukee firearm deaths; however, anecdotal information from the State Crime Lab suggests 9mm firearms were the "firearm of choice" in 1994.[8,12]

Firearm Modification—Increasing the size and barrel lengths of handguns may decrease firearm deaths. The majority of firearms involved in 1990 homicides in Milwaukee had barrel lengths of less than four inches and could easily be concealed in pockets, handbags, and the palm of one's hand. Reducing the number of bullets that can be fired from a firearm by reducing the magazine size may reduce firearm deaths. Loaded chamber indicators may decrease the likelihood of unintentional shootings. Potentially, the most effective modification for preventing firearm deaths would be to modify firearms so that only their owners could discharge them. A "Smart Gun" has been developed that includes an encoding ring, a decoder, and a custom grip fitted to the authorized user.[13] These types of technologies may dramatically impact all forms of firearm deaths, particularly homicide among adolescents and children who are legally prohibited from purchasing or possessing firearms in Wisconsin.

Building a Comprehensive Approach to Firearm Injury Reduction

Recognition of firearm injury as a public health problem in Milwaukee County is important. Public health strategies have resulted in significant decreases in other types of injury, most notably those caused by motor vehicles. Application of these strategies to the problem of firearm morbidity and mortality in Milwaukee County must encompass the following considerations:

- Host strategies (education) are most effective when combined with agent and environmental strategies.
- Requiring behavior change is challenging because of issues of enforceability and personal freedom.
- Strategies that provide passive, automatic protection to individuals have the greatest likelihood of reducing firearm injuries.
- Reductions in firearm morbidity and mortality will require a comprehensive approach which incorporates all three types of strategies simultaneously at local, state, and national levels

Questions to Consider When Implementing Firearm Injury Reduction Strategies

- Is the intervention designed to impact upon the agent/vehicle, host, or environment?
- What is the expected impact of the intervention and how does it fit within a comprehensive approach to reducing firearm injuries?
- Does intervention have a short- or long-range goal?
- Will the intervention's impact have a direct or indirect impact on firearm injuries?
- Will the intervention's impact have short-term or long-term consequences?
- Is the intervention targeted to the entire population or to populations at highest risk for firearm injuries? If the intervention is intended for the entire population, will it reach populations at highest risk? If it is intended only for populations at highest risk, is it appropriate for them?
- Is the intervention based on empirically-proven effectiveness or on lessons learned from the experience of others?
- Can the effects of the intervention be evaluated?

RECOMMENDATIONS

Based on the data presented in the full report, *Public Health Strategies to Reduce Firearm Injuries and Deaths in Milwaukee County,* the Milwaukee Academy of Medicine supports the following recommendations for building a comprehensive approach to reduce firearm-related injuries and deaths in Milwaukee County:

Host

- Schools and other organizations that implement violence prevention curricula should conduct vigorous evaluations to determine the level and extent of the impact of these programs.
- Violence prevention efforts should be combined with job training, counseling and treatment services for individuals and family members.
- Suicide prevention programs, that are culturally/ethnically specific, should be developed, implemented and evaluated for youth and the elderly.

Environment

- Community handgun initiatives should be encouraged. Evidence suggests an immediate (3–5 yr.) reduction in firearm-related deaths.[9]
- If a handgun initiative becomes law, efforts to rigorouly evaluate its impact on handgun injuries and deaths should be funded and implemented.
- Gun buy-back programs should be evaluated to determine their effectiveness in reducing firearm-related crimes, injuries and deaths.
- Strategies should be implemented and evaluated to increase the availability of publicly-funded substance abuse treatment centers and to decrease waiting periods to enter them.
- Activities, such as Safe Nights, which combine education about firearm violence with social and recreational opportunities, should be funded, expanded and evaluated to become part of the community framework, rather than one-time events.

Agent/Vehicle

- Wisconsin legislators should consider drafting and supporting legislation to require that all firearms manufactured and sold in Wisconsin be equipped with safety and personalization devices by 1998.
- Wisconsin and/or local legislators should collaborate with civic groups and physicians to educate state and/or Milwaukee County residents about the potential impact these laws would have on firearm injuries and deaths.
- Community groups, such as the Milwaukee Violence Prevention Coaltion, should actively support legislation aimed at requiring the addition of safety and identification devices to firearms.

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Monty Lutz, Wisconsin State Crime Laboratory, Firearms Division
James Mosley, The Milwaukee County Fighting Back Initiative
Edward Quebbeman, M.D., Ph.D., Medical College of Wisconsin
Tom Schneider, J.D., U.S. District Attorney
Police Chief David Steingraeber, Menomonee Falls Police Department
Reverend James White, The Milwaukee County Fighting Back Initiative
Jeni Wincek, R.N., Children's Hospital of Wisconsin

The SMS Alliance: Volunteer committment to a reduced level of violence in America

by Cecilia Podlusky, SMSA president

At the core of the Medical Alliance (formerly Auxiliary) is commitment to volunteer service. Physicians' spouses throughout Wisconsin will really come forward in the next several months as the Alliance works to help create awareness of the problem of violence in America. Members will distribute posters, sponsor conferences and do plenty of work behind-the-scenes. Some will literally lay down their lives in the hopes of helping people understand the problem of violence. Read on.

Things will get underway in October, which, by presidential proclamation, has been designated Domestic Violence Awareness Month. The AMA Alliance developed a logo and proclaimed Oct 11 as SAVE (Stop America's Violence Everywhere) Day. Here in Wisconsin, county alliances will be spending the day out on the streets. Members have been encouraged to participate in a project that provides a graphic illustration of the often-times fatal nature of domestic violence. Having chosen a public location such as the entrance to their local hospital or shopping mall, volunteers will lay down on the pavement and have their bodies outlined in chalk. Both adults and children will participate since abusers rarely discriminate based on the age of their victims. Each body will be marked with a fictitious name and a future date of death. A caption will then be chalked in. It will read: " Hundreds of Wisconsin women and children die from domestic violence each year. Don't allow your mother, daughter, child or friend to become the next statistic. Break the Silence... Begin the Healing."

In conjunction with this, also during October, the SMS Alliance will be placing 10 billboards at various well-traveled locations throughout the state. The billboard project is chaired by Sue Schemmel of Madison. The Maggie Springer Advertising Agency in Appleton donated their time and creative talents to develop the idea. The billboard depicts a family in a shattered picture frame. Domestic abuse has destroyed their hopes and happiness. Early warning signs of abuse are listed on the billboard.

Cecilia Podlusky, SMSA president

In order to reach even more potential victims of violence, the SMS Alliance has also printed 2,000 posters with the same image. County alliance members

have volunteered to place these posters (each with tear-off pads listing a local number to call for help) in dressing rooms, women's restrooms, hospitals and clinics in their area.

Various county alliances are also participating in workshops or becoming involved in the issue of domestic abuse in other ways. Alliances in Outagamie and Winnebago counties are sponsoring a symposium in Kimberly Oct 3. This all-day event will explore the unique role that health care providers can play in recognizing and responding to domestic violence. Program participants will learn to identify battered women, ask appropriate questions in their practices, learn how to document violence in the medical record and develop their knowledge of local resources.

Last year the Fond du Lac County Alliance worked with St. Agnes Hospital to develop a hospital based domestic violence program. This year they have an army of volunteers scheduled to work at an up-coming conference entitled, " Domestic Violence: We Are All Accountable." Fond du Lac Alliance member Barbara Lent will co-chair this workshop. It will address issues such as the possibility of change in both our society and in perpetrators of violence, restraining orders, elder abuse and how domestic violence affects youth. Scheduled for Nov 1, the conference is sponsored by the Fond du Lac Coalition Against Family Violence, Friends Aware of Violent Relationships and St. Agnes Hospital.

In La Crosse, Alliance member Jan Cogbill sits on the Domestic Violence Task Force. This group has published a manual which is being distributed to social service agencies, hospitals, clinics and businesses. The manual includes a protocol for recognizing, handling and referring domestic violence cases. The La Crosse County Alliance is a sponsor of this manual.

In November, the SMSWA will focus on a different aspect of violence. The Teen Workshop, which has been sponsored by the Alliance for the past 32 years will be held Nov 14 in Wisconsin Dells and Nov 15 in Stevens Point. The topics for this years conference are gangs, peer pressure, healthy choices and conflict resolution. Conference coordinator Carol Harding, of Neenah, has developed a program that includes former gang members, educators and lots of audience participation. More than 1200 students from all over Wisconsin are expected to attend.

The Alliance plans a continued focus on violence on into the foreseeable future. At this point various committees of the Alliance are busy determining the most effective way to tackle the subject of violence in the media. As always, the Alliance welcomes input, effort and support from all of Wisconsin's physicians spouses. ❖

Physician briefs

Mary Abdulky , MD, certified in internal medicine, will begin practicing at the Oconto Memorial Hospital within the next 15 months. She completed medical school and an internship at the University of Damascus in Syria in 1987; a 3-year residency program at Our Lady of Mercy Medical Center, Bronx, NY in 1993; and completed a two-year rheumatology fellowship at New York Medical College in New York City in June.

Mezen Beshara, MD, will join the staff at the Oconto Memorial Hospital during the summer of 1996 after completing a 3-year fellowship in cardiology at Our Lady of Mercy Medical Center in the Bronx. Graduating from the medical school at the University of Damascus and completing a 3-year internal medicine residency at Our Lady of Mercy Medical Center in New York in 1993, he became board certified in internal medicine in 1993.

M. Colette Cameron, MD, has joined the Physical Medicine and Rehabilitation Department at Columbia Hospital where she assumed the position of medical director of the Inpatient Rehabilitation Unit. She earned her medical degree at Northwestern University Medical School and completed her residency in physical medicine and rehabilitation at the University of Minnesota Hospitals.

Andrea Carroll, MD, * an internist recently joined the medical team at Two Rivers Clinic. She received her medical degree from the University of Iowa School of Medicine in 1990. She completed her residency at

Continued on next page

SMS Board of Directors

The SMS Board of Directors poses for an informal shot after the July board meeting.

Gunderson Clinic-Lutheran Hospital in La Crosse, between 1990-1993 where she also served as chief resident of internal medicine from 1992-1993.

Wayne Christie, MD, has joined the staff of McDonough Orthopaedic & Sports Medicine Center. He earned his bachelor and masters of science degrees in chemistry from Union College, Schenectady, NY, and his doctor of medicine degree from the Albany, NY, Medical College in 1977. He completed his orthopaedic surgery residency at the University of California-Los Angeles.

Maurice W. Chung, MD,* has joined the practice of Dr Richard A. Hogan and the medical staff of Door County Memorial Hospital. He received his bachelor of science degree in biology from the University of Illinois, Champaign-Urbana. In 1984 he received his medical degree from the Medical College of Wisconsin in Milwaukee. He completed his internal medicine residency in 1987 and 1989 at the Medical College of Wisconsin. He is board certified by the American Board of Internal Medicine in Gastroenterology and Internal Medicine and certified by the National Board of Medical Examiners.

Ronald Cortte, MD, * chief resident at Eau Claire Family Medicine Clinic, received a special residency teaching award for his contributions to education during the last year.

Robert W. Cox, MD, of Shorewood, has been appointed the new assistant professor of biophysics at the Medical College of Wisconsin. He is based at the Medical College's Biophysics Research Institute. He is formerly from Indiana University-Purdue University, Indianapolis, where he taught in the departments of mathematical science and computer information science since 1991. He is a 1976 graduate of California Institute of Technology with a bachelor of science degree in mathematics and a 1988 graduate with a doctorate in applied mathematics.

Norman Desbiens, MD,* internal medicine specialist, was selected by the students of the University of Wisconsin Medical School, Madison as the recipient of one of four UW Medical Alumni Association Distinguished Clinical Teaching Awards. He is a clinical professor at the UW and director of Marshfield Clinic's internal medicine residency program. He has been affiliated with the UW in a teaching role for nearly 20 years. He taught fourth year medical students in a rural internal medicine rotation while practicing in Ladysmith. Included with the award was a $500 honorarium which Dr Desbiens donated to the Internal Medicine Residency Program Educational Resources Fund, which provides educational materials for Marshfield residents.

Michael Flores, MD, * pediatrician, has joined the staff of Bay Area Medical Center and the Marinette-Menominee Clinic. His internship and residency were completed at Children's Hospital of Wisconsin in Milwaukee. He received his bachelor of science degree in biology from the University of the Philippines, Diliman, in Quezon City. He graduated in 1990 with a doctor of medicine degree from the University of the Philippines College of Medicine in Manila.

Kurt Fuchs, MD, a family practice specialist, will be opening an office in Prescott which is a branch of Regina Physician Services a division of Regina Medical Center (Minn). He received his medical degree in 1990 from the University of Minnesota. His family practice residency was completed at Hennepin County (Minn) Medical Center in 1993. He also has professional certification in Advanced Trauma Life Support and Advanced Life Support in Obstetrics.

William W. Greaves, MD,* was installed as an officer of the American College of Occupational and Environmental Medicine (ACOEM). He is an associate professor and director of the master's program in public health at the Medical College of Wisconsin, Milwaukee.

Mark S. Heberlein, DO, * family practitioner at the Vig Gundersen Clinic, Viroqua, has been honored for his outstanding work in the Air Force. Serving with a crew named the Twentieth Air Force air crew of the year for 1994 , Heberlein was a major in the Air Force before joining the Vig Clinic in Dec 1994. Major General Robert W. Parker wrote a letter of congratulations to Herblein stating, "This award clearly recognizes your crew's outstanding performance during a rescue flight in May (1994). Thank you for your hard work and dedicated efforts. It's a pleasure to have a flight surgeon of your caliber in the Twentieth Air Force."

Glenn, Hoberg, MD, was recently named the Family Physician of the Year by the American College of Osteopathic Family Physicians. He is a member of the state Medical Examining Board at the Department of Regulation and Licensing. He is past president of the Wisconsin Association of Osteopathic Physicians and Surgeons and has represented Wisconsin the past 13 years as a member of the American Osteopathic Association's House of Delegates.

Walter J. Hogan, MD, a gastroenterologist with the Pancreatic Biliary Center at St Luke's Medical Center, Milwaukee, has received the 1995 Schindler Lecture Award. It was presented by the American Society of Gastrointestinal Endoscopy for outstanding work in gastroenterology.

Purushottam W. Laud, MD, has been appointed associate professor of biostatistics at the Health Policy

Institute in the division of biostatistics at the Medical College of Wisconsin. He graduated with a master of science degree from Lamar State College of Technology, Texas, in 1971. In 1973 he received his master of arts degree from the University of Missouri-Columbia and in 1977 his doctorate degree. He is a member of the Institute of Mathematical Statistics, International Society of Bayesian Analysis and American Statistical Association, and is also an assistant editor of the Journal of Nonparametric Statistics.

Eric H. Locher, MD,* an internal medicine physician, has joined the staff of the Medford Clinic. A 1987 graduate of the Escuela De Medicina Universidad Tecnologica De Santiago, he recently completed a residency in internal medicine at the University of Wisconsin, Sinai Samaritan Medical Center in Milwaukee. He has also received training in infectious diseases at the Maine Medical Center in Portland.

John M. McKichan, MD, a family practice physician has joined the clinician team at Lake Country Clinic in Chetek. He completed his medical education at the University of Wisconsin Medical School in Madison and is certified by the American Board of Family Practice.

Thomas J. Malueg, MD, was elected to membership as a Fellow in the American Psychiatric Association (APA) in December and was awarded the honor at the 39th convocation of Fellows on May 22 at the American Psychiatric Association annual meeting in Miami, Fla. Advancement to fellowship is based on scientific attainments, dedication to the profession and contribution to the public good. Dr Malueg is currently medical director of United Behavioral Systems, a mental health specialty company of United Health Care in Minneapolis.

Brian Mamott, MD, has joined the Monroe Clinic's department of psychiatry and psychology. He received his undergraduate degree from State University College at Buffalo and his doctorate in psychology from the Illinois Institute of Technology at Chicago.

Neil S. Mandel, MD, was recently honored with a distinguished service award during the Medical College of Wisconsin's 82nd commencement. A professor of medicine, biochemistry and orthopaedic surgery, he is a globally distinguished leader in X-ray crystallography and kidney stone diseases.

Continued on next page

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Continued from previous page
Michael C. Mather, MD, * was named medical director of the Walk-in Family Care at the Aurora Health Center in the town of Pewaukee. He was a staff physician at Brookfield Medical Clinic and also served as an assistant medical director of St. Luke's Immediate Care center and as a walk-in physician at the Medical Surgical Clinic.

James W. Opoien, MD, * has joined the staff of the Marinette-Menominee Clinic and Bay Area Medical Center as a family practice specialist. He earned his medical degree in 1980 from the University of Miami and his doctorate in 1977 from Iowa State University.

Mary Ostermann, MD, * an obstetric and gynecology specialist, has recently opened a private practice at Beaver Dam Community Hospital. She received her doctorate of medicine from the University of Nebraska Medical Center and completed her internship and residency in obstetrics and gynecology at the University of Colorado Health Sciences Center, and is board eligible in obstetrics and gynecology.

Ken Ostermann, MD, * an obstetric and gynecology specialist, has recently opened a private practice at Beaver Dam Community Hospital. He obtained his doctorate of medicine from Hahnemann University in Philadelphia, Penn, and completed his internship and residency in obstetrics and gynecology at the University of Colorado Health Sciences Center in Denver, Colorado.

Thomas Peller, MD,* gastroenterologist at Group Health Cooperative in Eau Claire, was chosen for the "Newcomer of the Year Award" by the residents.

Lisa Reineke, MD, has joined the Sussex Family Practice in its comprehensive family health care clinic. She graduated from the University of Wisconsin at Eau Claire, receiving a Bachelor of Science degree. She received her medical degree from the University of Osteopathic Medicine and Health Sciences in Iowa. Postgraduate training, including internship and family practice residency was completed at Lakeview Hospital in Milwaukee.

Susan Skochelak, MD, associate professor of family medicine and associate dean for primary care and outreach at the University of Wisconsin Medical School, has been named Executive Leadership in Academic Medicine (ELAM) fellow. She earned her BS and MS degrees in biology from Michigan Technological University, her MD degree from the University of Michigan, and an MPH from the University of North Carolina, Chapel Hill.

Julie A. Swain, MD, cardiothoracic surgeon, will be joining the staff of the Michael E. DeBakey Heart Institute of Wisconsin at Kenosha Hospital and Medical Center. She received her bachelor's degree from the University of California, Los Angeles, and earned a medical doctor's degree under Debakey's guidance at Baylor College of Medicine in Houston. Her residency was completed in general surgery at Baylor and in cardiothoracic surgery at the University of California, San Diego.

Thomas Taft, MD, * an internist specializing in infectious disease, was the recipient of an award from the health department for reporting the first case of cryptosporidium on April 7, 1993, in Milwaukee. He is a member of the medical staff at St. Joseph's Hospital.

James Turek, MD,* has joined the Monroe Clinic's Women's Health Center to provide obstetric and gynecological care. He received his medical degree with honors at the University of Nebraska School of Medicine. His internship and residency in obstetrics and gynecology was completed at the Madigan Army Medical Center, Tacoma Washington. He is a member of the American College of Obstetrics and Gynecology, American Association of Gynecological Laparoscopists and the American Medical Association.

Ronald Waits, MD,* general surgeon for Marshfield Clinic, was named "Teacher of the Year" by the residents.

Donald Weber, MD,* obstetrician-gynecologist at Midelfort Clinic in Eau Claire, received the "Ten-Year Award" from the residency program faculty for his contributions to residency education over the past decade. He teaches residents the basic issues of prenatal care, such as gen-

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eral care and how to identify problems. Residents also learn about bedside manners.

Matthias Weiss, MD,* hematologist and oncologist, has recently joined the medical staff at the Marshfield Clinic Lakeland Center. He earned his medical degree from the universities of Freiburg and Heidelberg in Germany. His residency in internal medicine was served at Gundersen Clinic in La Crosse and he also completed a fellowship in hematology-oncology at Mayo Clinic, Rochester, Minn.

Thomas Wigton, MD, specialist in maternal-fetal medicine, has been appointed assistant professor of obstetrics and gynecology at the Medical College of Wisconsin. He earned his medical degree with honors in biochemistry and pharmacology at the Medical College of Ohio in Toledo, graduate studies were pursued in physiology at Ohio State University in Columbus, and he received his bachelor of science degree in biology from Denison University in Granville, Ohio, in 1981. He completed a fellowship in maternal-fetal medicine at Northwestern University Medical School and a residency in obstetrics and gynecology, winning first prize for his senior thesis at Rush Presbyterian-St Luke's Medical Center in Chicago, Illinois. He is board certified in obstetrics and gynecology and board eligible in maternal-fetal medicine, he has published nine scientific articles and presented more than a dozen research abstracts since 1991.

Scott Zahn, MD,* a pediatrician, has joined the Aurora Medical Group primary care clinic at Aurora Health Center Waukesha. He completed his residency at the Medical College of Wisconsin. ❖

Court concurs that bylaws give physicians contract rights

On Sept. 8 the Wisconsin Court of Appeals overturned a trial court decision to dismiss a lawsuit by 29 Janesville physicians against Mercy Health System Corporation, which operates Mercy Hospital in Janesville. The Court of Appeals said the trial court erred when it concluded that the medical staff bylaws did not constitute a contract. The SMS and AMA jointly filed a friend of the court brief on behalf of the plaintiff physicians before the Court of Appeals in this case.

The three-judge panel found the medical staff bylaws were a contract which bound the hospital as well as the medical staff. The panel also found the hospital's enactment of a policy which reduced the physicians' ICU/SCU privileges, established a new critical care committee that usurped the duties of the ICU Committee established by the bylaws, and unilaterally determined new medical credentials required to practice in the ICU/SCU, all breach the physicians' contractual rights.

The Court of Appeals ordered back the physicians' contract claims for a trial to determine the amount of damages the physicians suffered because of the hospital's breach.The Appellate Court also reinstated two tort claims against Mercy Hospital and Dr. Kerry Henrickson, which had been dismissed. It held that sufficient facts had been presented from which a reasonable jury could conclude that both Dr. Henrickson and Mercy had intentionally interfered with the rights of the 29 physicians.

The defendants have 30 days from the hearing date in which to file a petition asking the Wisconsin Supreme Court to hear the case. The Wisconsin Supreme Court can either deny the petition and refuse to hear the case or grant the petition. Last year the Wisconsin Supreme Court agreed to hear approximately 10 percent of those cases it was asked to review.❖

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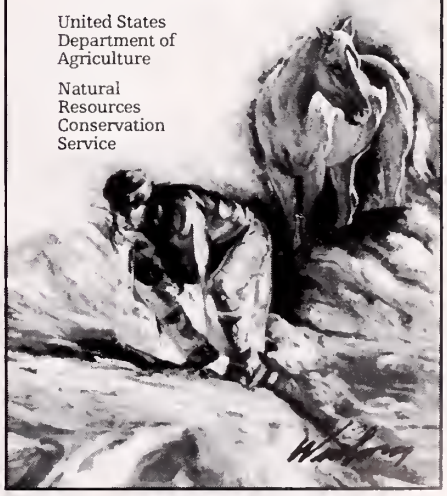

County society news

Dane. The Dane County Medical Society approved membership for the following physicians: Agni Guirish, MD; Deborah Arter, MD; Royal Eenigenberg, MD; Saad El-Naggar, MD; Anna Flynn, MD; Kathleen Friend, MD; Joseph Fruland, MD; Randy Heidel, MD; Mutsumi Ishii, MD; Eva Jedrzejewsli, MD; Suzanne Joseph, MD; Hannah Keevil, MD; Andrew Kessler, MD; Maureen Leahy, MD; Michael Philbin, MD; Peter Qualey, MD; Paul Reber, DO; Martin Sabatinos, MD; Eric Schweitering, MD; Charlene Sherd, MD; Robert Waterman, MD; Kevin Weiland, MD; and Tosha Wetterneck, MD.

Grant. Eric Nagle, MD, has been approved for membership in the Grant County Medical Society.

Lafayette. Joseph P. Gibes, MD, has been approved for membership in the Lafayette County Medical Society.

Marinette-Florence. The Marinette-Florence County Medical Society has approved membership for Michael A. Flores, MD; and James W. Opoien, MD.

Outagamie. The Outagamie County Medical Society approved membership for the following physicians: Joseph C. Graunke, MD; Glenn R. Huth, MD; Sharon L. Rink, MD; Mary Nordstrom, MD; Kent C. Schaefer, MD; and David A. Toivonen, MD.

Polk. The Polk County Medical Society approved membership for George H. Pfaltzgraff, MD.

Portage. Thomas R. Guse, MD; and Ralph M. Locher, MD, have been approved for membership in the Portage County Medical Society.

Racine. The following physicians have been accepted into the Racine County Medical Society: R.Stephen Callaghan, MD; Kenneth J. Kurt, DO; James F. Miller, MD; and Michael S. Nagy, MD.

Washington. The Washington County Medical Society approved membership for the following physicians: John G. Fink, MD; Susan E. Park, MD; Dean M. Pollnow, MD; Colleen J. Reichel, MD; and Dean Chier, MD.

Waukesha. The Waukesha County Medical Society approved membership for Terry A. Zarling, MD; James Leonhardt, Md; Joseph Donofrio, MD; Glenn Caine, DO; Amy Fox, MD; Julie Laufenberg, MD; Gregory Nelson, MD; Steven Hunter, MD; Steven C. Humphreys, MD; Debra Schaeffer, MD; and Michael J. Ludkowski, MD.❖

SMS president honored by peers

Marcia J.S. Richards, MD, of Milwaukee, has been named as a fellow of the American College of Radiology (ACR). Dr Richards practices at St Luke's Medical Center. The announcement was made during the ACR annual meeting held September 9-13, 1995, in Boston, Mass.

Selected for her outstanding contributions to the field of radiology, Dr Richards was named as one of 130 new fellows by the College's Board of Chancellors.

Fellowships in the College are awarded to members for significant scientific or clinical research in the field of radiology or significant contributions to its literature. Criteria for selection also include performance of outstanding service as a teacher of radiology, service to organized medicine and an outstanding reputation among colleagues and the local community as a result of long-term superior service.

ACR is a national organization serving some 30,000 radiologists, radiation oncologists and radiological physicists, with programs focusing on the practice of radiology and the delivery of comprehensive radiological health services.❖

AMA awards

The Wisconsin physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates members of the SMS.

* Alexander, Janice
* Bormann, Joel A.
* Luckey, William T.
Moe, Ronelle M.
* Westman, Jack C.❖

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17. Signature and Title of Editor, Publisher, Business Manager, or Owner — Date

Warren H. Hamilton Editor

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Created by the Territorial Legislature in 1841 and now representing nearly 8,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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Our cover: This edition of *Wisconsin Medical Journal* focuses on the health risks of tobacco; articles throughout the Socioeconomic section designated in the table of contents by this symbol: address the issue. Cover art courtesy of the American Cancer Society, Wisconsin Division and the American Heart Association, Wisconsin.

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President's page
Differences and diversity: Shall it be confrontation or creativity?

To break through creativity, we must defer judgment. That is, learn to accept all ideas, without prejudice, and examine them each in turn.

-- Scott Isaksen

MEDICINE IS CHANGING, but so are the medicine men.

As I struggle with the rapidly changing panorama of medicine, responding to issues as diverse as Clinton and contracts, Medicare and mandates, too often I forget that we the physicians are also changing. This lapse in my memory is particularly ironic, since I was at the front of the recent wave which delivered more women to the shores of medical practice. I am part of the change. Perhaps my forgetfulness can be attributed to having passed the half century mark since I wrote the last President's page.

Much of the transformation in the physician population is obvious, like the increase in women in medicine, the increase in group practice, and the increased emphasis on primary care. Today's new physicians also reflect the diversity of our America, coming from dissimilar cultural and ethnic backgrounds. No longer do most physicians look like that familiar family doctor examining a bare-bottomed child on the magazine cover created by Norman Rockwell for the *Saturday Evening Post*. Many younger physicians also have different expectations of the profession of medicine as well as outside the profession. Not only are physicians changing in physically obvious ways, but we are changing in significant ways that are not readily apparent to the eye. Our personal values in life are becoming different. Many of us are less willing to sacrifice our personal and family time, as has been done so often by physicians in the past. It is perhaps such less obvious changes that offer the greatest potential for either additional problems or fresh creative approaches for our profession. We have an opportunity. Will we seize it?

Marcia J. S. Richards, MD

Medicine has responded in part to these changes in the physician population with new styles of practice. Many "old-timers" might reflexively condemn or criticize new approaches to the practice of medicine. I would suggest that we withhold our judgment until we see if medicine's evolution creates some better ways, not just different options, for practicing medicine. Not all changes will result in improvements, just as not all attempts at evolution of various species were successful; some went on to extinction. But some cases allowed for the survival of a more fit species in a changing environment.

Where in this changing landscape of physicians and their practices does organized medicine fit? Do

we need an organization to which all physicians can belong as we become more diverse?

I believe the answer is a resounding "yes." Although my specialty society can represent me well on issues related to radiation oncology, the broader issues that effect each one of us, or our patients, can more effectively and efficiently be pursued by an organization representing all of us. Witness the recent success of tort reform in Wisconsin, or the needed dialogue on the current Medicare and Medicaid debate in Washington. Could we function as well without an all inclusive physician organization? I think not. Common concerns are addressed best with a coherent, collective, and vigorous response.

Yet today's profession of medicine increasing finds its members with differing views. In these situations, organizations such as the SMS can function to facilitate bringing together the subsets of individuals who share similar ideas or concerns. Where we differ, the SMS can provide a safe harbor to discuss and debate issues out of the public eye.

But if broad-based physician organizations, such as the SMS and AMA, are to continue effectively, I and many others believe we will need to change. No longer can we rest on the haunches of tradition, nor can we risk becoming as irrelevant as a slide rule in the age of pocket calculators. Perhaps we should stop doing things that others may do better. Perhaps we need to streamline our structure so we can respond more quickly in this age of instant information. Perhaps we no longer need to be organized in conventional ways, but to create a more rapid response structure. And absolutely, we need to find ways of presenting the majority views of the membership, yet recognizing and accepting the right of other members to present their strongly held minority views, without allowing the differing opinions to destroy or weaken our organization.

I believe as physicians working together we can build on our areas of commonality and accept our differences, if we all remember that as physicians we will always have more issues on which we agree, than those on which we disagree. Let's work together creatively to mold our future and that of our profession of medicine. If we don't, others will.❖

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EVP Report
Medicare

"Politics is not an exact science"
--Prince Otto von Bismarck

By year's end, we all may be seeing a dramatically reshaped federal government. The House of Representatives has passed its version of a budget reconciliation bill that contains $270 billion dollars in Medicare cuts over a seven-year period. The Senate also passed its version. Because the two bills have numerous differences, both will go to a joint house and senate conference committee where a group of very few people will make some significant decisions about government.

The president has promised to veto whatever comes out of conference unless he obtains substantial concessions from the conferees. If the bill is vetoed, the votes are not there to override and a new bill would likely be developed. Something should eventually pass and it is in the best interest of quality health care that the "something" include the Medicare provisions passed by the House of Representatives on Oct. 19. (See sidebar for details on Medicare reform package.)

The Medicare reforms are not perfect and have their faults. To quote an old adage, *"There are two things people shouldn't see made -- sausage and laws."* I think this quote is especially true with this Medicare reform bill. Overall though, I do think the AMA deserves real kudos for its grassroots work with the leadership of the House. The AMA defeated several amendments that would have weakened this bill and they helped shape this bill into a package with some good proposals for the future of medicine.

Two Wisconsin congressmen played key roles in the debate: Scott Klug (R-Madison), a member of the Energy and Commerce Committee Health Sub Committee; and Jerry Kleczka (D-Milwaukee) a member of the Ways and Means Committee Health Sub Committee. Although they both were serving on key health committees, that is where any simi-

Continued on next page

A delegation of Wisconsin physicians and staff travelled to Washington, D.C. in September to lobby their congressional representatives on Medicare reform. Pictured (front, left to right) Wayman Parker, M.D., Marcia Richards, M.D., Mike Kirby, SMS Director of Government Relations, Steve Whittow, SMS Field Representative, Mark Andrew, M.D.; (back) Donn Dexter, M.D., Timothy Flaherty, M.D., Steve Dankle, M.D., Bruce Kraus, M.D., and Tom Adams, SMS EVP.

Continued from preceding page
larity ended.

Congressman Klug deserves both physicians' and patients' thanks. He was a key player in offering amendments outlined in the sidebar article. At the request of SMS, he also stepped to the plate and offered an amendment to convert Wisconsin to a single geographic payment area for Medicare. This budget-neutral amendment passed and is now included in the package. The State Medical Society and American Medical Association appreciate his hard work on the legislation.

Along with the thank yous, come some thumps on the head. As a member of the House Ways and Means Committee, Congressman Kleczka had ample opportunities to help the AMA and Wisconsin physicians with many aspects of this bill. Unfortunately, he chose to not vote for any of the AMA amendments and he actually pushed an amendment to eliminate the provision in the bill that creates provider sponsored networks.

He also supported amendments in committee to eliminate the $250,000 cap on non-economic damages in medical malpractice cases and to eliminate the modest antitrust protections for physicians. As part of his rhetoric during the amendment process, he banged his hand on the table andcriticized perceived physician motives. All of this came as a surprise to those of us who visited with him a week and a half earlier. In those conversations, we felt he understood our concerns and would be helpful. Guess not.

Finally, thanks are also well deserved for all the physicians of this state who took the time to call their representatives with comments on this legislation. In September, the SMS took a delegation of physicians to Washington, DC to discuss this monumental bill with their local congressmen and senators. Reprinted on the preceeding page is a picture of those physicians who took the extra step to help develop meaningful health care reform in this country.❖

On Oct 19, the House of Representatives passed its Medicare reform bill by a 231-201 vote. The Senate passed its version on Oct. 27. From there the Senate and the House will meet in conference committee to develop a single plan and will probably complete its work in December. President Clinton has said he will veto both plans if they stand as they are today. To avoid the veto pen, it appears both the House and Senate will need to bring the president in on discussions of the plans.

Physician reforms in the House bill are:

- Replaces current physician update formula that would have resulted in annual rollbacks in the Medicare conversion factor. All physicians will now be subject to a single conversion factor.
- A $250,000 cap on non-economic damages.
- Exempts physician office labs from CLIA requirements except for pap smears.
- Creates provider sponsored network options for physicians to offer competitive alternatives to insurance plans.
- Provides antitrust relief and added protection for physician self-regulation activities.
- Overhauls Stark I and II self referral rules.
- Creates Medical Savings Account option.
- Limits reductions for Indirect Medical Education payments and creates a medical education trust fund and work force planning commission.
- Adopts patient protection provisions including appeals in deselection cases, disclosure of utilization review criteria and greater physician input on insurance plan policies.

I encourage you to call your congressman and express your appreciation for those who supported our efforts on this bill. Wisconsin representatives who voted for the bill include: Congressmen **Neumann, Klug, Gunderson, Petri, Roth** and **Sensenbrenner**. Those who voted against the bill were: Congressmen **Kleczka, Barrett** and **Obey**. For direct phone numbers, contact the SMS Governmental Relations Department at 1-800-362-9080.❖

Letters
Money is not evil

To the editor: After reading Marcia J.S. Richards' President's Page (Vol. 94, No. 8), it is clear that such flawed thinking has produced a philosophy whose implementation in this country will continue to destroy quality medical care, and ultimately the freedom on which this nation was founded.

Her statement, "On the route of most evil--the love of money" implies that efforts by man to provide goods and services for a fee, are either inherently evil, or achieved by illegal or immoral means, is pure nonsense. Money is not evil, nor its acquisition. It is solely a means of exchanging perceived value. Morality knows no fiscal boundaries. Immoral people can be found in all walks of life. To equate monetary success with evil, is to promote the virtuosity of being poor.

Her rendition on "managed competition" and the potential pitfalls affecting quality of care within such a system, failed to address the central issue. "Managed competition" (an oxymoron, by the way) cannot succeed (unless success is measured by forceful compliance) because it is economically and morally corrupt. It places the physician as the economic risk taker and thus sets up an adversarial relationship between the physician and the patient. It regulates control of patient physician interchange to cookbook mentality in which any variation outside the norm must be approved by some central authority. We have all had to deal with prior authorizations where the person on the other end of the line asks you, "Do you spell carotid with a 'c' or 'k'?" Is this what we want?

To make the statement that rationing of care will be "made prospectively--based on solid scientific data (I presume statistical outcomes), and shaped by predominant physician and societal thought," is to rationalize rationing as okay as long as some higher authority makes the rules. I take it the physician is supposed to feel morally relieved when he tells the patient, "I cannot help you because those are the rules created to benefit 'societal needs,' not your needs but let's go ahead and appeal your case--even though you might not be around by the time a decision has been made."

It is clear that Dr Richards lacks the insight and courage to deal with the disease afflicting and destroying today's medical care--collectivism. If Dr Richards is so interested in quality of care, why doesn't she reject such concepts as managed competition?

To say that this is what's coming, so let's make the best of it, is to give up the principle of liberty for both patient and physician and replace it with the principle of force.

Practical, workable alternatives to medical care that retains patient-physician freedom to interact are out there.

Medical IRAs, private pay, insurance for catastrophic medical needs are all workable and retain the principles of liberty. Dr Richards, nor anyone else, cannot take any system that is inherently evil and expect good moral outcomes.

When you compromise your principles, you are eventually bickering over which color rope you wish to be hung by. I hope others in our organization have the wisdom to see that the only way to maintain cost effective, quality medical care is to reject collectivism and implement programs that promote freedom of choice. We still have the power to make a difference, but we are rapidly running out of time.

--*James P. Fogarty, MD*
Barron, Wisconsin

President's response

Dear Dr Fogarty:

I am glad to know that you read the President's Page. I agree with you that providing service for a fee is appropriate. I am only concerned if the efforts rewarded are for withholding services rather than providing them for patients. I, too, want to ensure that managed care companies reimburse us fairly as physicians. I guess my writing was not clear in intent.

Additionally, I am not an advocate for or against managed competition, but rather an advocate for physicians and patients in the current environment...which happens to be increasingly managed competition. I see medical leadership as needing to help its members to navigate through the current environment, whatever it may be. I do not pretend to pass judgment on the current situation, but rather to promote the best level of medical practice possible with the evolving practice of medicine.

I wish I could believe like you that it were so simple as to stonewall managed care. However, others outside of our profession have made it the norm, at least where I practice. I need to participate to be able to care for patients in the Milwaukee area and so do many other physicians throughout our state. Thus I can either not utilize my skills as a physician and not earn a livelihood for my family, or I can participate in managed care. Perhaps you have a different choice where you live.

Thanks for your response. I will continue to apply my ethical beliefs to the practice of medicine, whatever the future may hold.❖

Fair reimbursement

To the editor: In response to Dr Graves' letter in the most recent medical journal, I would like to make several comments. The first is that I believe that practice overhead differentials are greatly exaggerated. Building material costs, property taxes, medical supply costs, employee benefits, medical liability costs and so forth do not appear to me to be substantially different from urban to rural areas. In fact, supply costs are more expensive in rural areas. He further appears to make the point that the Milwaukee County Society supports fair reimbursement rates for all Wisconsin physicians, but only if the rate paid to Milwaukee County physicians is increased as well as payments to physicians in other areas who are discriminated against.

This was the point of my first letter. I wish to thank the Madison area physicians for being supportive of their lesser paid brethren and for having the foresight to realize that unless physicians pull together for one another, third party payers are already being successful in dividing and conquering.

--D. Mark Lochner, MD
Waupaca❖

Infant dehydration

To the editor: In this computer age from time to time I consult an on-line bibliography under topics in which I have an ongoing interest; one of these is hypernatremic dehydration. Accordingly, on a recent search I turned up hypernatremic dehydration in breast-fed infants in this Journal, 1995;94(3):143-145 by Kine et al.

While their case reports are interesting I believe they are conceptually in error. The sodium content of breast milk is probably not relevant to the infants' dehydration; it occurs when water intake is very low. Failure to get water occurs because the infant is not stimulating the mother's breasts sufficiently to obtain adequate volume for whatever reason (usually faulty technique). Absent or low water intake is common to almost all hypernatremia except salt poisoning, which I believe this is not.

Concentrations of 31 and 64, mEq/L (cases 1 and 3) of sodium with an intake of 100-120 ml/Kg/d of breast milk are easily handled by the infant renal system. Ninety-two mEq/L (case 2) is on the high side, but without knowing the volume produced and imbibed it is probably only a sign of very low milk output. As pointed out in the paper, when the first milk is produced the solute concentration is high but the volume is low. This low water intake leads to the hypernatremia, not the sodium concentration in the milk. The sodium intake in these low volume situations will be trivial.

--Laurence Finberg, MD
Professor of Pediatrics Emeritus, SUNY at Brooklyn
Clinical Professor of Pediatrics University of California-San Francisco

Author's reply

We do not disagree with Dr Finberg. Ingestion of low volumes of breast milk invariably will lead to dehydration, but this is not consistently associated with hypernatremic breast milk. Even in the first few days where there is a high solute load in the milk, levels of sodium ranging from four to ten times the normal limits are unusual. Therefore, we believe that both volume and high sodium in breast milk contributed to the hypernatremia found in our patients. Unless it can be clearly shown that infants ingesting acceptable volumes of hypernatremic milk can clearly handle the solute load, salt poisoning must be a consideration in evaluation of these infants.

--Narendra Kini, MD
Assistant Professor of Pediatrics Medical College of Wisconsin❖

Hearsay
A touch of humor for Wisconsin physicians

What a rat!

A tourist wanders into a back-alley antique shop in San Francisco's Chinatown. Picking through the objects on display he discovers a detailed, life-sized bronze sculpture of a rat. The sculpture is so interesting and unique that he picks it up and asks the shop owner what it costs.

"Twelve dollars for the rat, sir," says the shop owner, "and a thousand dollars more for the story behind it."

"You can keep the story, old man," he replies, "but I'll take the rat."

The transaction complete, the tourist leaves the store with the bronze rat under his arm. As he crosses the street in front of the store, two live rats emerge from a sewer drain and fall into step behind him. Nervously looking over his shoulder, he begins to walk faster, but every time he passes another sewer drain, more rats come out and follow him. By the time he's walked two blocks, at least a hundred rats are at his heels, and people begin to point and shout. He walks even faster, and soon breaks into a trot as multitudes of rats swarm from sewers, basements, vacant lots, and abandoned cars. Rats by the thousands are at his heels, and as he sees the waterfront at the bottom of the hill, he panics and starts to run full tilt.

No matter how fast he runs, the rats keep up, squealing hideously, now not just thousands but millions, so that by the time he comes rushing up to the water's edge a trail of rats twelve city blocks long is behind him.

Making a mighty leap, he jumps up onto a light post, grasping it with one arm while he hurls the bronze rat into San Francisco Bay with the other, as far as he can heave it. Pulling his legs up and clinging to the light post, he watches in amazement as the seething tide of rats surges over the breakwater into the sea, where they drown.

Shaken and mumbling, he makes his way back to the antique shop.

"Ah, so you've come back for the rest of the story," says the owner.

"No," says the tourist, "I was wondering if you have a bronze lawyer."

--Source unknown

If you have a humorous contribution for Hearsay, an occasional *WMJ* column, we invite you to send to us at the *Wisconsin Medical Journal*, 330 E. Lakeside, Madison, WI 53715. Contributors may remain anonymous.

"Ms. Webster, this is my clone, Dr. Howard the Second, he will be doing my paperwork from now on."

Gradual education

The graduate with a science degree asks, "Why does it work?"
The graduate with the engineering degree asks, "How does it work?"
The graduate with an accounting degree asks, "How much will it cost?"
The graduate with a liberal arts degree asks, "Do you want fries with that?"

Those troublesome taxes

As the IRS sees it: America is the land of untold wealth.
The IRS received a batch of buttons in the mail with this notation: "You got the shirt last year."
Said the old lady to the IRS clerk: "I do hope you will give my money to a nice country."

Continued on next page

Continued from preceding page

Legislative garble from the halls of Wisconsin politics:

"As long as I'm in the Senate, there will not be a nuclear suppository in Northern Wisconsin."

"These numbers are not my own; they are from someone who knows what he's talking about!"

"If you are going to start cleaning up the state, don't start in my part of the state."

"There is nothing wrong with clean, pure cigar smoke."

"I know that he wants to require everyone to expose themselves to everyone else."

"People planning on getting in serious accidents should have their seat belts on."

"I want to be candidly frank."

"That's enough to make one's back leg stand up."

"There are three sides to every argument."

"This is a good health care bill. Take it from one who has survived a terminal heart attack."

"Good communication is essential--even if it isn't clear."

Infamous exit line

"If there's anyone here whom I have not insulted, I beg his pardon"

--Composer Johannes Brahms.

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Soundings
County Hospital and medical education: A personal reminiscence and eulogy

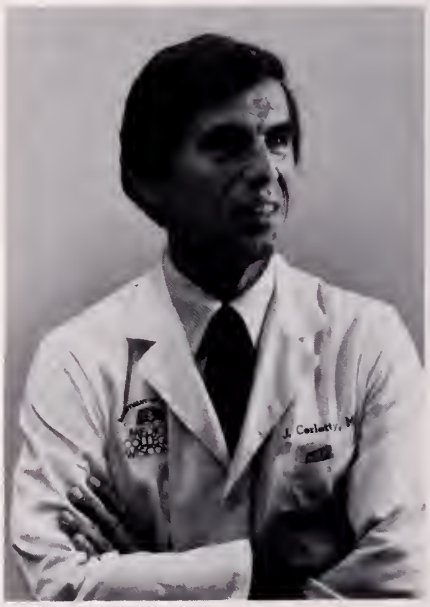
James M. Cerletty, MD, Milwaukee

For more than 100 years, an important mission of Milwaukee County has been medical education. The Doyne Hospital and its precursors, the Milwaukee County Medical Center, the Milwaukee County General Hospital and the County Hospital (which date back almost to the Civil War era) have been the training ground for physicians, nurses and a host of other health care providers. The basis of the relationship between the county and Milwaukee's medical schools has been the shared commitment to medical education.

The first medical school in the state was the Wisconsin College of Physicians and Surgeons, which opened in Milwaukee in October 1893. The following year, the Milwaukee Medical College and School of Dentistry was organized. From the onset, these two institutions sent their students to County Hospital for much of their clinical training.

In 1913, these colleges merged to form the Marquette University School of Medicine. This new school continued to use County Hospital for student clinical experiences. By the time Marquette Medical School had been transformed into the Medical College of Wisconsin in 1970, the marriage between County Hospital and medical education in Milwaukee had already been flourishing for more than 75 years.

Since the merger of Milwaukee's two proprietary medical schools into Marquette University School of Medicine in 1913, and its subsequent evolution into the Medical College of Wisconsin, more than 8,000 students have graduated, carrying with them into their careers, much of the clinical lore they gleaned at County. An equal number of physicians worked in this hospital as interns, residents and clinical fellows over those years, preparing themselves to deliver quality health care throughout the nation. Of the 11,270 physicians in practice in Wisconsin today, more than 2,000 are graduates of the Medical College of Wisconsin or Marquette Medical School; another 2,100 of this state's physicians took their internships and residencies at



James M. Cerletty, MD

the medical school's affiliated hospitals.

Almost all of these physicians had a rewarding clinical educational experience at Milwaukee County Hospital. There truly was a century long marriage between Milwaukee County and medical education. That marriage had a fecundity in the provision and advancement of health care of nonpareil impact.

My first personal recollections of "County" were as a 6-year-old boy. I grew up in a blue- collar neighborhood in Milwaukee, now considered part of the "central city." Other than a rare excursion to downtown Milwaukee to visit the museum, we were a stay-at-home family. The Milwaukee County Zoo was then in Washington Park, just a two-mile walk from my backyard. Wauwatosa (pronounced "WaLk-ahh-two-Zabh" by the Teutonic octogenarian who lived next door) was a distant western suburb, and was known solely (by my family) as the site of the area's county mental hospitals. I later learned that these institutions bore the less than euphemistic names of the Asylum for the Chronically Insane (ACI) and the Hospital for Mental Diseases (HMD).

Whenever I behaved in an especially bizarre fashion (as I did frequently as a child), my maternal grandfather threatened to take me to Wauwatosa. Later in life, while working on my family tree, I learned that my paternal great-grandfather and one of his sons had spent their last years as inmates there. (Please, no comments about the hereditary nature of insanity.)

When my older (by 8 years) brother was 16, he was involved in a minor traffic accident and was taken to County General. My father was awakened at 2 am, and had to drive to the hospital to retrieve him. From the conversation at the breakfast table the next morning, it was unclear whether my father's disgruntled response was due to the accident, the timing of the nocturnal call, or the fact that County Hospital was at the western edge of the world. In any case, I decided at that moment that I never wanted to see the County Hospital, or at least, I didn't want my father to know I was ever there.

It is likely that my family had an earlier contact with County. My family's patriarch in this country,

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Milwaukee County General Hospital (1880s) - torn down for the Children's Hospital.

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Giovanni Antonio Cerletti came to Milwaukee in 1858 (guess where he came from). He was listed in the city directory as a laborer and peddler. As best I could determine in my genealogical searches, he died in 1870. The county did not keep death records before 1872, and his body is not registered in any of the city's cemeteries.

Where was Giovanni Antonio? When construction for the MCW Clinic at Froedtert was started several years ago, the bulldozers began to disinter bodies. Hundreds of graves were eventually opened; they proved to house the skeletons of indigents who had died in the second half of the nineteenth century. Part of the area under construction was a parking lot I had used for years. Although I can't prove it, I think I had been parking all that time on my progenitor, Giovanni Antonio!

By age 10, I was no longer a stranger to Wauwatosa. I went swimming at Hoyt pool, and caught crayfish in the Menomonee river in the adjacent park. I was introduced to frozen custard at Gilles. In my teens, I dated several girls from this suburb. I began to visit Emil's bar (now defunct) on 104th and Bluemound, which served those not quite at the legal age, and was often inhabited by nurses from the County Hospital. But I never entered the fabled building by the lagoons until my freshman year in medical school.

The occasion of my first visit was in essence a field trip for first-year students to give us a hint of clinical medicine. The entry to the hospital at that time was through what is now the Murphy Library on the third floor, an area that directly faces the lagoons and Wisconsin Avenue. We were met in the lobby by a young poised and articulate staff surgeon, who took our group to the wards, introduced us to patients, briefly reviewed their problems and demonstrated, with their consent, pertinent physical findings.

Our small group was then allowed to observe a surgical procedure. The surgery rooms were on the 5th floor, in an area most recently utilized as an orthopedic unit. A small amphitheater, which accommodated about 15 people, allowed us to sit adjacent to and above the operating table. In retrospect, the whole scene must have looked like a picture from a history of medicine textbook. We were all gowned, masked and enraptured. We were on our way to becoming doctors!

A patient with a prior empyema was undergoing a decortication procedure; our view from 10 feet away didn't allow us to judge the competence of the surgeon.

I **definitely** was impressed with the hospital. Even though the patients were housed on large open wards, they were being cared for with respect and dignity. The physicians and nurses that I met seemed devoted to their patients. On that day, I gained the positive impression of the commitment of the County Hospital's health care teams to the welfare of their patients, no matter what their social class, that has never been diminished.

My next visit to County Hospital was several months later, when a group of freshman medical students toured the Hospital for Mental Diseases. Our visit corresponded almost to the day of the clinical introduction of the first phenothiazine, Thorazine. The drug had not yet been made available to these unfortunate patients. This sea of humanity was racked by a host of mental diseases, in some cases worsened by our cruel treatments of the past. Those who had their surgical lobotomies walked about zombie-like, with little interpersonal reactivity. Some of the more agitated patients screamed at us to leave; I thought they viewed us as intruders, gazing at their misfortune. (They were right). I felt that our understanding of their diseases was primitive, and our treatments medieval. But there was an exception. The gentle supporting nature of the attendants and nurses who worked with these patients demonstrated a caring humanity and understanding of rare and special quality. These were the type of people who worked at County.

In the latter part of my freshman year in medical school, I took a job as an admitting clerk at County General, working the third shift on weekends. At that time, the County ran an Emergency Hospital on 24th and Wisconsin Ave.

That's where most of the nocturnal action was at that time, as I was to learn later as a moonlighting resident. The highlights of my clerking job were the early morning coffee and doughnuts sessions with Hilda, the elevator operator, and Al, the garrulous night watchman; this trio easily could have solved all the world's problems.

At this job I also learned to type, and, as anyone who has seen me fumbling at my computer keyboard will attest, I didn't learn very well. One of my duties was to inventory the morgue at midnight, an eerie task that might be the basis of another tale, the convoluted story of the missing body.

Residents from all disciplines would stop by my admitting desk, sharing with this neophyte stories of their interesting patients and their satisfaction with the teaching program. They all advised me to take my postgraduate training at County.

In my junior year, my first rotation was on general surgery. The staff moguls of that department were the aging, but still vital, Joe King and Ed Bachhuber.

Everyone was agog over the rumor that the new chairman would be someone of major repute. They were right. The following year, Ed Ellison took over the department, raising its clinical and academic reputation to new heights. Many were the giants of academia who walked the wards and clinics of County. Some are international giants, like Ed Ellison, Paul

Kimrnelstiel, Dan McCarty and others; the national giants include Tony Pisciotta, Konrad Soergel, Francis Murphy, Jack Lemann and many more; the regional giants are legion. These people were and are legendary clinicians and teachers. Their research endeavors improved our understanding of mechanisms of disease, and thus helped countless patients over the years. By their leadership and example, they improved the quality of health care delivered to the patients at County.

Much of the teaching in those days was done by volunteer faculty who were in private practice in the community. These attending staff assignments were highly pursued, because of the prestige involved and the satisfaction gained in this teaching role. Many staff also felt this was a continuing educational experience because of the wide diversity of patients at County, and the "cutting edge" input of the full-time faculty experts at this institution. The best and brightest of the area's practitioners were active in this role. Many of the readers of this *Journal* will remember their role in this educational endeavor. A prototype of this group who is still active in our department is Carl Junkerman. Having Dr J. as your staff was the goal of all medical students and residents.

The first month of my senior year was spent on ward medicine at County, specifically on women's medicine on 3 East. Some of you readers may never have seen the reasons that the term "ward medicine" was ever used. An external glance at the County Hospital building reveals two large wings on each of the east and west ends. Areas that were divided into small rooms and offices in the late 1970s had previously been wide open and spacious wards.

Sixteen beds, with only a draw curtain between them, lined the two walls of each area. When the census rose, additional beds were added. Togetherness was a literal description of ward medicine. The service was busy, the teaching of medicine outstanding, the patients improving and grateful for our care. We were making a difference.

In the late evening, the team of residents, interns, students and nurses would review the day's events and relax. In those days, the hospital's pharmacy stocked beer (it

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Milwaukee County General Hospital about 1948-49. Unit in upper left corner was hospital from 1880-1928.

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was said to improve the appetite). On occasion, we would order bedtime beers for our confirmed teetotaler patients, and consume the brews at these sessions. Our attending staff, Ed Lennon, would often drop by with a pizza for the group.

Dr Lennon, later dean and president of the Medical College of Wisconsin, was William Osler reincarnated. He was the greatest teacher of them all, an opinion shared by many, many hundreds of students and housestaff who worked at County. He was my role model for a career in medical education.

The patients were memorable. I learned from them about their diseases, but more importantly about how they coped with these problems. They provided me with an education about human nature. A 70-year-old woman, with a history of multiple clinic and ER visits, and brief hospital stays for what invariably turned out to be the results of her hypochondria, entered with back pain and anemia. When the diagnosis of myeloma was made, she was elated, and called all her relatives, almost joyously telling them that she had a lethal disease. She was no longer the girl who cried "wolf."

A 30-year-old mother presented with a problem that taught me the important lesson that one must avoid snap judgments. She entered the hospital with a severe headache 2 hours after being discovered with her husband in the act (*inflagrante delicto)* by her 7-year-old son. What all the medical team members thought was an appropriate psychosomatic headache, turned out to be a leaking cerebral aneurysm.

A woman in her late 60s, suffering from hepatic failure secondary to biliary cirrhosis, spent her last weeks on 3 East. The two of us spent many hours together. Our medical support efforts were palliative, but not curative. As she lay dying, this callow young student, frustrated at his and medicine's failure to save her, sat at her bedside, holding her hands and finally breaking into tears. In her last hour of life, this special woman reversed our roles. It was she comforting me, assuring me that I had done everything and was going to be a great doctor.

After graduation, I spent 3 years away from Milwaukee and County Hospital, pursuing my medical career. But something drew me back. After my residency and fellowship, I was fortunate to be offered the position of residency program director. I should have kept a diary. Countless medical students, interns and residents have passed through my life and have shared with me to some extent their sorrows and joys, their weaknesses and strengths, their gripes and their jests, but mostly their energy and enthusiasm. On some days, they have made me old beyond my years, but, in the main, they have kept me young.

Many stories have evolved throughout those years; they may merit retelling in the future. Some of the more memorable ones include Jesus in the coronary care unit, gorillas in the ICU, fabulous parties in Sergeant Hall, and, most of all, the many instances when laughter proved to be the best medicine.❖

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Selected topics in exercise stress testing

Len Scarpinato, DO, FACP, FCCP, FAAFP, Milwaukee

More than ever before, exercise stress testing (EST) has become a focus for primary care physicians. But there are definite indications and contraindications for EST administration. Criteria may include when cardiology referrals should be made and what role the family physician should play in follow-up with coronary artery disease patients. There also are considerations for using EST for individuals with atypical chest pain or with patients after bypass surgery, angioplasty, or the coronary artery disease diagnosis. There even are distinct criteria for administrating EST to women. This article will attempt to examine the numerous factors surrounding EST's growing use by primary care physicians. *Wis Med J*.1995;94(11):607-610.

A changing environment

EST once had been the domain solely of cardiologists. However, primary care physicians have been performing treadmill exercise stress testing for some time. In response to this, the American Academy of Family Practitioners (AAFP) developed and presented a national EST workshop at its annual meeting. With a subsequent grant, most state medical societies' annual meetings were visited by a core group of AAFP exercise stress test faculty, who taught at minimum a four-hour course, "Introduction to Exercise Stress Testing for the Primary Care Physician."

Our purpose here is not to provide an exercise stress testing overview for the primary care physician, which has been elegantly and eloquently done before.[1-5] Instead, this article discusses EST's indications and contraindications, as well as exercise stress testing in specific patient populations of interest to the primary care physician.

Indications for Treadmill Exercise Stress Testing

The American College of Cardiology (ACC) and the American Heart Association (AHA) have classified criteria for treadmill exercise stress tests into three classes[6]:

Class I, when general agreement exists that justifies testing, can apply to:

- Diagnosing coronary artery disease in males with atypical symptoms for ischemia.
- Evaluating and assessing functional capacity for coronary artery disease patients.
- Reviewing patients' symptoms from exercise-induced arrhythmias.

Class II, when opinions vary on the value and appropriateness of frequent application, is indicated for:

- Diagnosing coronary artery disease in women with any kind of angina pectoris.
- Diagnosing coronary artery disease in digitalis patients or complete right bundle-branch block patients.
- Measuring functional capacity and therapeutic response to cardiovascular drugs in patients with coronary artery disease or congestive heart failure.
- Analyzing variant angina patient evaluations.
- Performing serial exams in known coronary artery disease patients.

Class III, where there appears to be little value for patient stress testing, applies to:

- Evaluating premature ventricular contractions with no other evidence of coronary artery disease.
- Measuring serial functional capacity evaluations as part of cardiac rehabilitation programs.
- Assisting in the diagnosis of coro-

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nary artery disease in the Wolff-Parkinson-White syndrome, or complete left bundle-branch block patients.

Contraindications for Treadmill Exercise Stress Testing[7]

EST is not recommended for patients diagnosed with the following conditions:

- Acute myocardial infarction.
- At-rest angina pectoris.
- Left ventricular dysfunction of a severe symptomatic nature.
- Pericarditis, myocarditis, or endocarditis.
- Severe aortic stenosis or arterial hypertension.
- Acute pulmonary embolism, infarction, thrombophlebitis, deep vein thrombosis or serious general illness.
- Life threatening dysrhythmias.
- Neuro-muscular-skeletal conditions, precluding exercise.
- Uncontrolled metabolic disease (diabetes or hyper- or hypothyroidism.)
- Patient inability or lack of informed consent.

Referrals to cardiology

Despite increasing EST administration by primary care physicians, there are occasions when cardiology referrals should occur prior to the treadmill exercise stress test. In particular, male patients with typical angina pectoris may be considered for a "gold standard" test (i.e. coronary catheterization) due to a lack of any major changes between their pre- and post-test probability of coronary artery disease with a treadmill EST. ACC or AHA Class II or Class III patients might do better with a cardiology referral rather than an exercise stress test.

Cardiology referrals after the treadmill EST administration will be highly individualized; however, a strongly positive test with chest pain, significant ST depression, or hypotension merits cardiology consultation. In some cases, physicians should make the phone call immediately. At other times, it makes sense to admit the patient if those changes are persistent and of long duration. In fact, any significantly positive treadmill results require cardiology input, and any primary care physician administering EST needs an ongoing professional relationship with a cardiologist for such cases and to temper potential overreads of questionable findings.

The family MD's role in coronary heart disease patient follow-up

Family physicians play significant roles in coronary heart disease patient follow-up based on the individual and his or her interaction with the cardiologist. In some situations the family physician may lose total contact with a patient immersed in the world of cardiac rehabilitation and potentially headed for angioplasty or coronary artery bypass grafting. Other times, the family physician can be an effective counselor or facilitator for all testing levels or technical and surgical procedures. The family physician can administer the treadmill EST after coronary artery disease is diagnosed. And developing good rapport with the cardiologist involved is clearly a primary component, forming the basis for any role the family doctor plays with these patients.

The minimally symptomatic individual (atypical symptoms)

The atypical-chest-pain patient can be a prime candidate for utilizing the treadmill EST. A complete history and physical is warranted, with special attention paid to coronary artery disease risk factors such as hypertension, hypercholesterolemia, diabetes history, or family history of a close relative with either documented coronary artery disease or coronary event. Physical findings, such as xanthoma, xanthelasma, or other evidence of arteriosclerosis also can be significant.

When I perform treadmill exercise stress tests, I use them as part of an atherosclerosis consultation. Prior to the test, and with the primary care referral resident present, I review the patient's atherosclerosis risk factor profile. How the patient can improve that profile becomes part of my recommendations regardless of the test's results.

Positive treadmill ESTs also can help reduce risk factors. In previous research published in abstract form, smokers reprimanded following a positive treadmill EST test had a higher immediate smoking cessation rate than those with a negative treadmill test.[8] (None of these ESTs were significantly positive.) With the morbidity-mortality rate from stable coronary artery disease fairly low, I've had success with compliant patients by risk factor reduction. This approach puts a heavy responsibility on the patient to quit smoking and follow through with other risk factor reduction. I repeat the treadmill EST at 6-month or yearly intervals, and perform further diagnostic tests if pain increases, or if the patient doesn't follow the program. The patient is given medications such as PRN sublingual nitroglycerine; if they are hypertensive they get calcium channel blockers.

Exercise stress test after coronary artery bypass grafting and percutaneous transluminal coronary angioplasty

In early EST studies after coronary artery bypass grafting, treadmill exercise stress testing identified nonpatent saphenous vein grafts accurately. However, a larger landmark study of 217 patients indicated that treadmill stress testings after coronary artery bypass grafting had a low incidence of false positive tests (between 14% and 33%), but an excessive incidence of false negative tests (from 55% to 75%). The high incidence of normal treadmill exercise stress tests in the presence of residual coronary artery disease limited its usefulness.[9]

If one compared post-operative

and pre-operative treadmill exercise stress tests, post-operative ST depression wasn't as reliable as pre-operative in predicting ischemia. However, blood pressure and heart rate responses, aerobic capacity, arrhythmia generation, and ST response should be considered as a whole with the knowledge of the patient's previous performance.[10]

When percutaneous transluminal coronary angioplasty was used on only single vessel disease, it was understood that anginal pain was a reliable predictor of restenosis or disease progression in another vessel. Post percutaneous transluminal coronary angioplasty ST depression resolution was considered a reliable indicator of success.[10]

In a more recent study attempting to detect restenosis after either single or multivessel disease elective percutaneous transluminal coronary angioplasty, researchers found that, while the treadmill exercise stress test added independent information from the symptom complex, 20% of the patients with restenosis had neither recurrent symptomatic angina nor exercise induced ischemia at a six month treadmill EST. Researchers concluded that the treadmill EST needed to be supplemented with a more definitive test.[11]

For these reasons, adding thallium scintigraphy to the treatment may be appropriate. In one post-coronary artery bypass grafting study, only one patient with incomplete revascularization went undetected. This corresponded to a positive predictive accuracy of 92%.[12]

Thallium scintigraphic-enhanced EST is especially useful in patients who develop chest pain after coronary artery bypass grafting or percutaneous transluminal coronary angioplasty. Lack of stress-induced perfusion defects at significantly elevated heart rates and work loads is highly accurate in ruling out restenosis. Unfortunately, a false positive scan up is possible up to 6 weeks following percutaneous transluminal coronary angioplasty, despite the absence of restenosis or infarction.[13]

Exercise stress test status post coronary artery disease diagnosis

The place of the treadmill EST in the care or work up of patients diagnosed with coronary artery disease after catheterization, presuming no revascularization such as coronary artery bypass grafting or percutaneous transluminal coronary angioplasty has been done, can be determined by ejection fraction and number of vessels involved. A study of 936 patients one to six months after suffering a heart attack or unstable angina pectoris indicated that exercise stress testing alone wasn't useful in identifying patients at increased risk for coronary problems.[14]

In three-vessel disease with low ejection fraction, there 's no survival advantage with coronary artery bypass grafting.[15] The literature conflicts regarding three-vessel disease and normal ejection fraction. Coronary artery bypass grafting was found to offer better survival in one study[15], whereas there was no difference in mortality in the other.[15] A National Institute of Health study found that three-vessel patients with normal ejection fraction and no severe ischemia seen on exercise stress test did very well on medical therapy[17]; all patients were alive, in fact, 4 years later. None were on anti-anginal medication during the test and all were N.Y. Heart Classification I or II. Another group from the Mayo Clinic didn't fare as well. These patients were taking anti-anginal medication during the test, but more than one third were functional class III or IV. The incidence of serious cardiac problems was approximately 41%.[18]

Annual mortality during a mean study period of 4.6 years averaged between 1% and 2% for three-vessel disease and 0% for one- to two-vessel disease patients refusing coronary artery bypass grafting.[19] Such results are reassuring.

One viable option may be performing periodic treadmill ESTs on patients after an initial catheterization. If the patients worsen, they can be recatheterized or sent to coronary artery bypass grafting or percutaneous transluminal coronary angioplasty as appropriate. In the intervening time, primary care physician attempts at risk factor modification can have a more powerful effect secondary to the positive exercise treadmill test.[8]

Treadmill exercise stress testing in women

More common false-positive results seen in premenopausal women occur due to the relatively low prevalence of coronary artery disease among women. The specificity and sensitivity of ESTs are equal in both genders after adjusting for the difference in prevalence. According to Peberdy & Ornato, there's no true gender-related difference in exercise test sensitivity or specificity. The number of true-and-false positive results is identical in men and women matched for the presence and severity of coronary artery disease.[20]

As women age, false-positive rates decrease and ST depression becomes a more reliable determinant of coronary disease.[10] The rate of false-positive ST depression is higher in women than men of the same age.

Computer analysis involving multivariate statistical techniques largely had been done in men, but a Belgian researcher reported an ECG study in women prior to coronary angiography. Using multivariate statistical techniques, she found that the treadmill EST had comparable specificity between genders. She also found that three variables predicted an accurate reading in women: maximum work load, heart rate increase, and depressed ST-segment in lead X (unfortunately a lead in the orthogonal three-lead system X,Y,Z). This multivariate analysis increases the utility of the EST in women.[21]

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In a study of 234 women and 326 men who underwent coronary angiography, estrogen status significantly improved the pretest clinical diagnosis of coronary disease in women to the point of increasing the diagnostic accuracy of the combined clinical and exercise test data to that of men.[22]

Women often are immediately tested with thallium-201 scintigraphy enhanced EST, but there are gender-related difficulties in image interpretation with this test. A female breast can mimic an anteroseptal infarct by making the anterior wall appear "colder" than the inferior wall. Interestingly the male diaphragm (sans breast tissue) can attenuate the radioisotope, causing false inferior wall defects.[23]

Conclusion

The treadmill EST is commonly used by family physicians to diagnose and prognosticate symptoms and diseases. The family physician will have his or her best success with minimally symptomatic patients; patients after bypass surgery, angioplasty, or heart catheterization; patients with evidence of coronary artery disease; and women.

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Thrombocytopenia and pancreatic carcinoma

Christopher J. Sweeney, MBBS, and Robert S. Witte, MD, La Crosse

More and more physicians are finding increasing evidence of carcinoma-related immune-mediated platelet destruction. Such is the case of the patient with carcinoma of the exocrine pancreas associated with profound thrombocytopenia that follows. The patient died before studies could be completed. However, well-recognized causes of drug reactions, DIC, chemotherapy and marrow infiltration were able to be excluded. Although anti-platelet antibodies weren't isolated in the serum, the patient's response to steroids and its similarity to other cases with evidence of carcinoma-related immune-mediated platelet destruction makes this process most likely in the case presented. *Wis Med J*:1995;94(11):611-615.

The case in question

A 58-year-old white male, complaining of abdominal pain three months prior to admission, underwent a cholecystectomy. The procedure resulted in a diagnosis of adenocarcinoma of the head of the pancreas. Physicians performed a Whipple procedure 2 months prior to admission.

The patient's recurrent abdominal pain 2 weeks prior to admission prompted a CT scan which revealed liver metastases and extensive retroperitoneal adenopathy (Figure la and lb). Review of the patient's systems on day of admission revealed significant anorexia, early satiety, cachexia, and steatorrhoea, but no bruising, bleeding or thrombotic episodes. His only medications were pancreatic replacement enzymes and hydrocodone. A CT-guided liver biopsy (Figures 2a and 2b) confirmed metastatic adenocarcinoma consistent with primary pancreatic carcinoma. A routine CBC on day of admission revealed a platelet count of 14,000 per cumm which had fallen from 196,000 per cumm 18 days prior to admission. He was admitted to the hospital.

The patient's past medical history included 15 years of idiopathic osteoporosis and a 1970 appendicectomy. Family history revealed that his mother died of pancreatic cancer. The patient also had a 60-pack-a-year smoking history and drank 10 grams of alcohol daily.

Physical examination showed the patient as an afebrile, cachectic, mildly jaundiced man with oral candidiasis. His skin showed no signs of petechiae or purpura but his abdomen had an ill-defined 8 x 6 cm mass in the right upper quadrant. The remainder of the examination was within normal limits.

The patient's hemoglobin was 10.0g/dL with normochromic normocytic indices. There were 12.2 K/cumm leukocytes with 81% neutrophils and 13% lymphocytes. Evaluation of the peripheral smear (Figures 3a and 3b) showed a marked reduction in the number of platelets, most of which were large, and the presence of target cells. The INR was 1.35 (Range "R" :0.88- 1.26), APTT 26.5 (R: 17.9-29.4); Total bilirubin 4.0mg/dL (R:0. 1-1.3), alkaline phosphatase 331IU/L (R:0-140) and alanine transaminase 80IU/L (R:0-35). A bone marrow biopsy revealed normal cellularity and normal megakaryocytes, myeloid hyperplasia with normal maturation but a scarcity of mature segmented granulocytes (fig 4a and 4b). There was a reactive increase in plasma cells. Erythropoiesis was normal. Fibrin degradation products, fibrin soluble monomers and D-Dimer were all negative. Anti-platelet antibodies were negative by ELISA testing by the Blood Center of South-Eastern Wisconsin.

Physicians began administering 60 mg of Prednisone daily on day of admission. On the second hospital day, the patient developed a shaking chill and a temperature of 38.5 degrees Celsius. A blood sample of the patient grew E. Coli. Ceftizoxime was started. Septic screen revealed no source for the infection. Dexamethasone was substituted due to its longer action profile at nine mg daily on the second hospital day.

The patient's platelet count fell to 8,000 on the second hospital day and then increased to 41,000 on the sixth hospital day. The patient was discharged, but died 6 days later. No autopsy was performed.

What happened?

The patient in question had pancreatic adenocarcinoma associated with an unexplained profound thrombocytopenia, but had not had chemotherapy, radiotherapy, acute leukemia, or DIC to account for the thrombocytopenia. The lack of clinical features of sepsis prior to admission made this a less likely cause of the thrombocytopenia. Other causes deemed unlikely due to the lack of clinical evidence were splenic vein obstruction with secondary hypersplenism and platelet consumption from adenocarcinoma-induced thrombosis. Therefore, an immune mediated process, such as an ITP-like syndrome, is the most likely etiology. The latter has been recognized with Hodgkins Disease, CIL, non-Hodgkins lymphoma and

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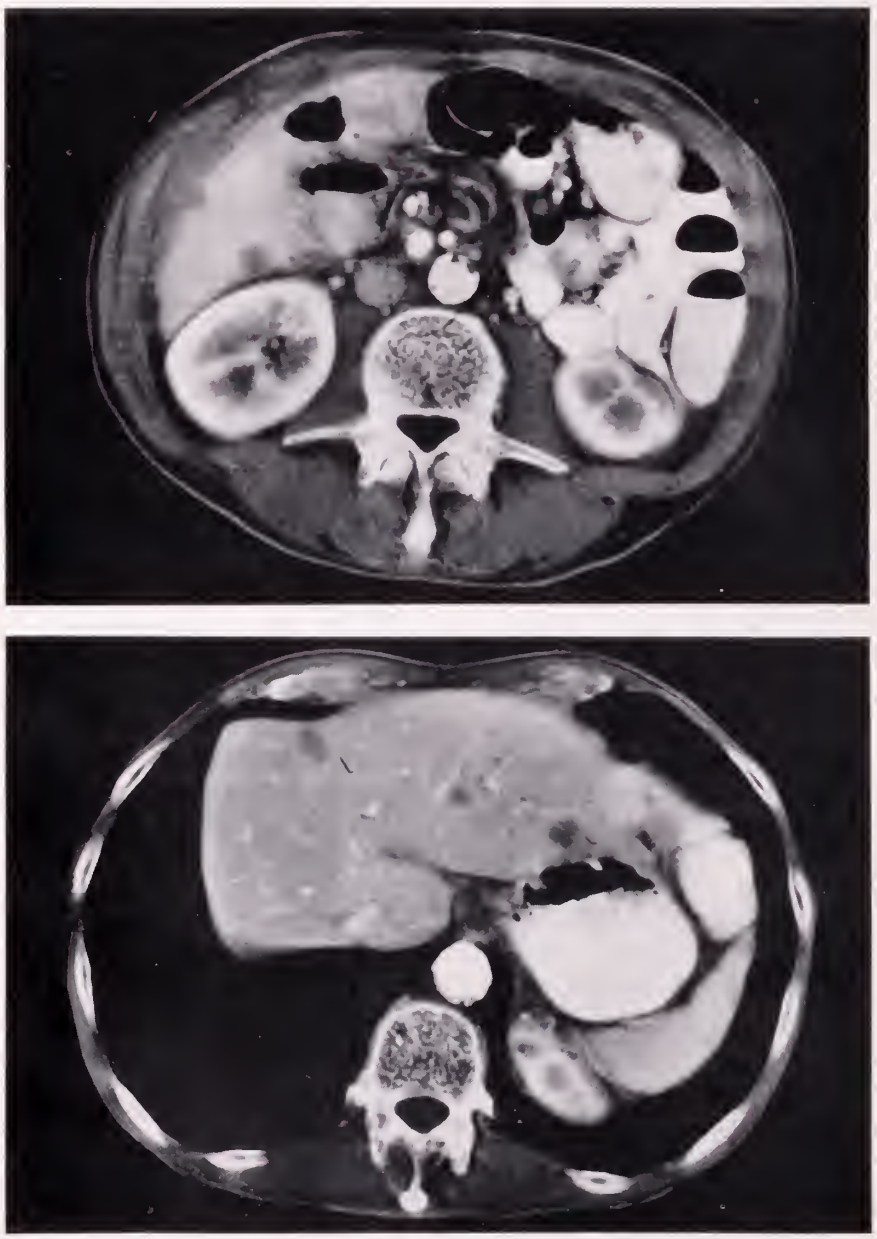
acute lymphoblastic leukemia. It's less well recognized in immunoblastic sarcomas and carcinomas of the lung, breast, rectum, gallbladder and testis.[1-3]

Diagnostic criteria[1-3] for immune-mediated thrombocytopenia are thrombocytopenia without anemia and normal or increased numbers of normal erythrocytes on peripheral smear. There also should be no evidence of DIC or drug induction. The features[1-3] of this condition are:

1) The mean age of the patients are older (i.e. 58 years) than the true ITP patients, consistent with the distribution of cancers in an older population;
2) More than 80% are symptomatic with bleeding, petechiae, or purpura, and the platelet count is less than 30,000;
3) Symptoms commonly respond to high dose steroids (60 mg per day), but the effect is usually transient.
4) The course is similar to classic ITP. It's thought the antibodies may arise from antibody cross-reactivity with tumor cells and the antibody-tagged cells are removed from the circulation by the reticuloendothelial system, especially the spleen. Research also has shown that 25% of patients with lymphoproliferative disorders with ITP have anti-platelet antibodies.[3] Thrombocytopenia disproportionate to granulocytopenia, normal or increased marrow megakaryocytes, or a rapid fall in transfused platelets offer clues to diagnosing this condition.



Figures la and lb. Enhanced CT scans of the abdomen demonstrating liver metastases and extensive retroperitoneal adenopathy.

Therapy for this condition must be individualized to the patient's situation. Choices include one or more of the following: platelet transfusion, corticosteroids, splenectomy and treatment of the primary tumor.[1,2,5,7,8] Documenation has shown each to have its relative benefits.

This partiular case isn't thought to represent hypersplenism because there was no evidience of splenomegaly on CT scanning or of hemolysis and neutropenia. DIC also was excluded due to the absence of the laboratory markers of this consumptive process, including the lack of erythrocyte fragmentation on the peripheral smear. The only exception was the mildly prolonged INR at 1.30 seconds. However, this was most likely due to vitamin K deficiency from poor oral intake. The bone marrow biopsy result also excluded marrow invasion. The one area of interest is the lack of a brisk megakaryocytosis. This could indicate the loss of a humoral factor preventing megakaryocytosis (see below). Since there was no clinical evidence of sepsis at the time of biopsy, bone marrow depression secondary to the sepsis is far less likely.

An immune-mediated process

may be likely due to the exclusion of other causes, the response to corticosteroids, and its similarity to many other case reports. One such case links thrombocytopenia with hepatocellular carcinoma and complete resolution of the latter after a liver transplant.[6] After all other causes were excluded, researchers in this case proposed that the etiological agent was a carcinoma-associated factor inhibiting megakaryocyte maturation. Corroborative evidence was normal bone marrow except for megakaryocytes at various stages of differentiation with "rare thrombocytogenic megakaryocytes." The platelet lifespan was a normal 7.5 days, indicating no peripheral destruction.

In contrast, some case reports[7-8] show a similar clinical picture of solid tumors, but with the presence of anti-platelet antibodies. In these cases, bone marrow revealed an increased number of megakaryocytes and a shortened platelet survival time. Although the authors of these articles didn't say so, it could be argued that the increased number of megakaryocytes is secondary to a humoral mechanism reacting to the thrombocytopenia. By extrapolating this argument, it could be proposed that the bone marrow in the case of the hepatocellular carcinoma[6] results from the inability to mount a compensatory response. The recent isolation of thrombopoietin offers further support for this argument. This humoral factor, also known as mpl ligand, is produced by the liver and known to stimulate megakaryocytopoiesis.[12] Therefore, both in our case and the patient with hepatocellular cancer, it can be speculated that the loss of liver parenchyma and hence thrombopoietin resulted from the absence of a compensatory brisk megakaryocytosis.

There also have been other cases implicating the presence of a substance liberated by the solid tumor resulting in inhibition of thrombopoiesis. Giogio and colleagues[9] describe a case of an excocrine pancreatic carcinoma containing endocrine cells which liberated ACTH and resulted in diabetes and hypokalemia, but not florid Cushing's syndrome. The patient also had an unexplained leukopenia and thrombocytopenia and a humoral factor was presumed to have inhibited hematopoiesis. Similarly, Aabo and colleagues,[10] reported a metastatic islet cell carcinoma secreting insulin, glucagon, and gastrin with a hypoplastic bone marrow which had an androgen responsive pancytopenia.

Chemotherapy normalized the peptide levels, resulting in a complete hematological remission. Investigators also observed that injection of the patient's serum, obtained

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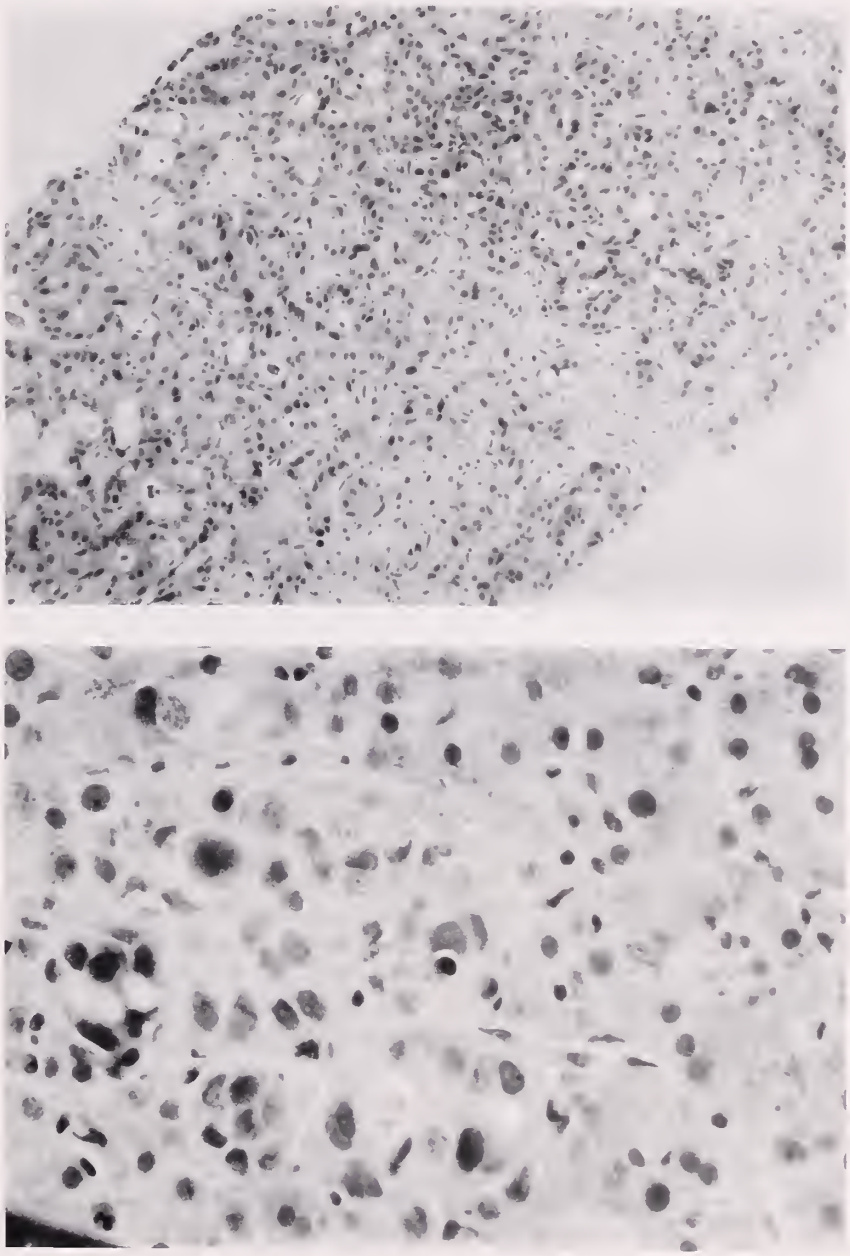
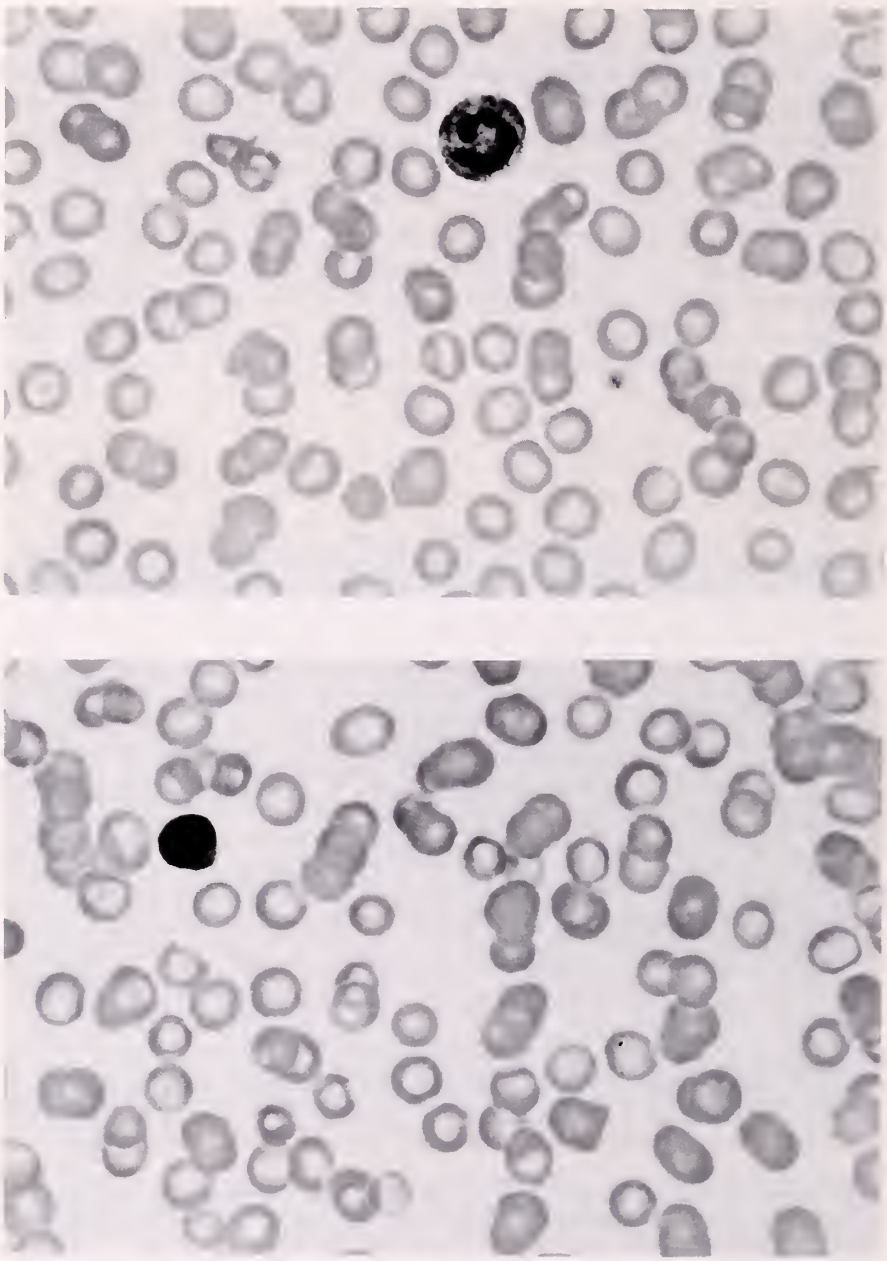


Figures 2a and 2b. Photomicrograph of liver biopsy demonstrating metastatic adenocarcinoma consistent with primary pancreatic adenocarcinoma.



Figures 3a and 3b. Peripheral blood smears demonstrating normochromic normocytic red blood cells and a few target cells with a marked platelet reduction, the majority of which are large.

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prior to chemotherapy, into a rat's peritoneum caused pancytopenia. This was considered further supporting evidence implicating a humoral factor.

Alternatively, Cummings and Mazur,[9] describe two cases of breast cancers associated with ITP and splenic metastases. They comment that 6% to 13% of all solid tumors have splenic metastases at autopsy, of which 30% to 50% can only be seen under a micrscope, tend to occur late and not produce symptoms. They conclude it was unlikely that a peculiar subtype of breast cancer resulted in the thrombocytopenia. It also was stated that the occurrence of ITP and splenic metastases together is rare and that spleen, tumor and platelet interaction is unusual. They propose that the splenic metastases manifested as ITP and that this is why splenectomy can result in cure. However, no definite statement regarding whether the spleen is integral or coincidental to the ITP can be made due to a scarcity of well-documented cases of involvement of the spleen. However, the comment that splenic involvement may be integral because removal results in cure is flawed by the fact that spleen removal results in the eradication of a large proportion of the reticuloendothelial system.

Kozlowski and colleagues[11] report another case scenario in which thrombocytopenia and a solid tumor has been found. They describe the presence of anti-platelet antibodies and a lupus anticoagulant in a patient with primary bronchogenic carcinoma and autoimmune thrombocytopenia. Corticosteroids and plasmapheresis normalized the partial thromboplastin time and resulted in the disappearance of the anti-platelet antibodies.

From the various cases described in the literature, it's clear there are many tumor-related causes for thrombocytopenia. Further, once drugs, radiotherapy and DIC have been excluded, immune-mediated or serum factors inhibiting hematopoiesis should be considered. The two possible etiologies in this case are subclinical endotoxemia or an immune mediated process, the later either by platelet destruction or thrombopoiesis inhibition. Patient response to corticosteroids and its similarity to other cases are supportive evidence for an immune-mediated process.

Unfortunately, the patient succumbed to the cancer before tests could be performed to determine if anti-platelet antibodies coated his platelets. If these were negative, an alternative mechanism of antibodies against the megakaryocytes could be conidered. Obviously, more work is required in this area.

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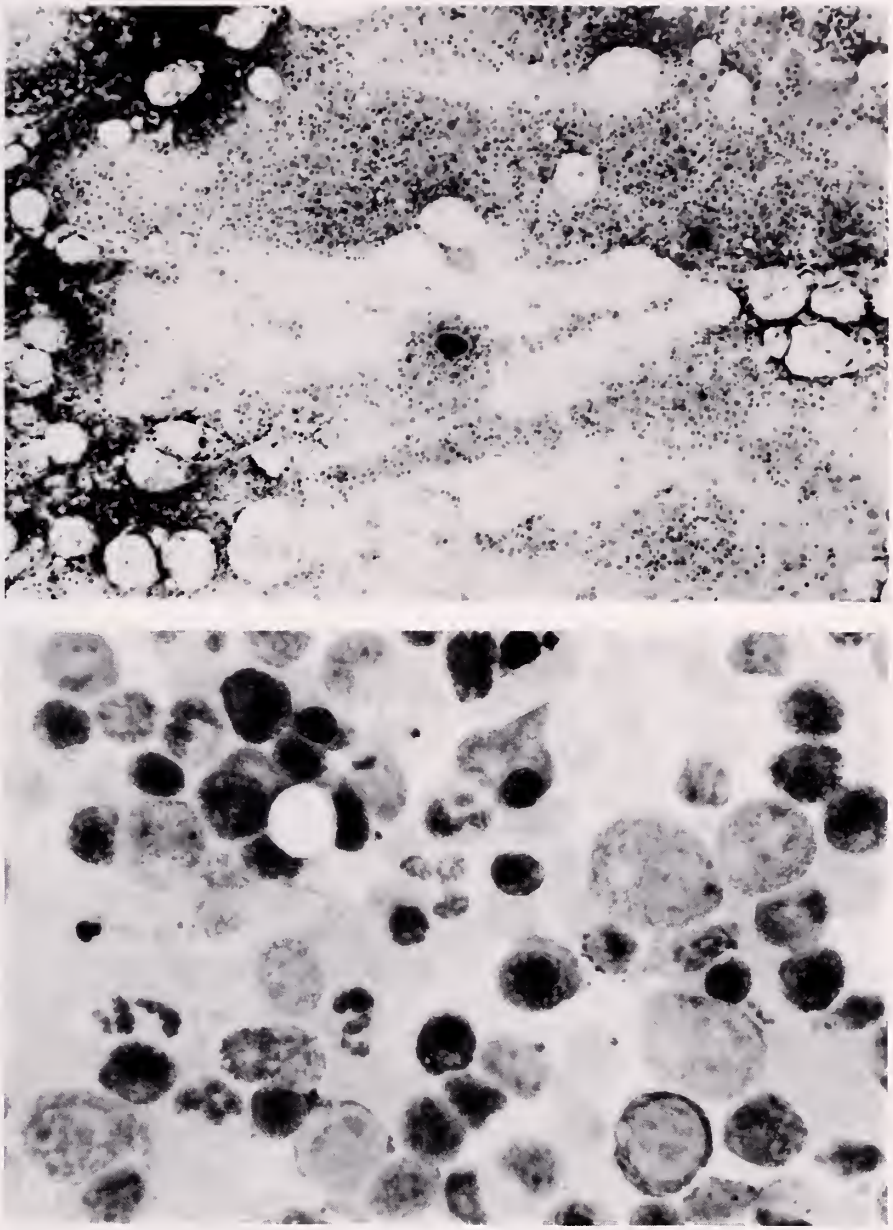

Figures 4a and 4b. Bone marrow biopsy demonstrating normal cellularity, normal megakaryocytes, myeloid hyperplasia with normal maturation, but paucity of mature segmented granulocytes. There also is a reactive increase in the plasma cells with normal erythropoiesis.

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Public health

Desire and efforts to quit smoking among cigarette smokers in Wisconsin

Anne M. Marbella, MS, and Peter M. Layde, MD, MSc, Milwaukee, and Patrick Remington, MD, MPH, Madison

This research studied the desire and attempts of cigarette smokers in Wisconsin to quit smoking. Data were based on the 1993 Wisconsin Division of Health's Behavioral Risk Factor Surveillance System (BRFSS). Among the 23% of respondents who were current smokers, 79% said they wanted to quit smoking and 60% said they had quit smoking for a day or more in the preceding year. High rates of wanting to quit and having tried to quit were found in all demographic subgroups of smokers studied. Compared to lighter smokers, heavy cigarette smokers (20 or more cigarettes per day) were less likely to have tried quitting in the past year, but were almost as likely to want to quit. These results demonstrate the great demand for smoking cessation services among smokers in Wisconsin and support for efforts to increase the use and effectiveness of these interventions. *Wis Med J.1995:94(11):617-620.*

Cigarette smoking is the most important cause of preventable deaths in the United States. An estimated 400,000 deaths each year in the US[1] and 8,700 deaths each year in Wisconsin[2] are attributed to tobacco use. Associations between smoking and morbidity and mortality from cancer (lung, esophageal, oral cavity, pancreatic, kidney, and bladder) and cardiovascular disease (coronary artery disease, stroke, and high blood pressure)[3] have been clearly established. Smokers able to successfully quit show a decline in this excess risk as the duration of their abstinence from cigarettes increases. Overall mortality rates for former smokers approach those of non-smokers after 15 years of abstinence.[4]

Widespread information about the health risks of smoking and benefits of quitting have convinced many smokers to attempt to quit. With over half of the 54 million smokers having at least one office visit a year and most visiting a physician four times a year[5], the physician has ample opportunity to initiate smoking cessation discussions. Yet several barriers exist which prevent physicians from trying to assist their patients in smoking cessation. Lack of reimbursement for preventive services, lack of time, and lack of interest on the patient's part have been mentioned by physicians as reasons why they have not emphasized smoking cessation with their patients. In this analysis, we will address the issue of patients' interest in quitting by measuring Wisconsin smokers' desire to quit smoking and their attempts at quitting smoking.

Methods

Information obtained from the 1993 Wisconsin Behavioral Risk Factor Surveillance System (BRFSS) was used in this analysis. The BRFSS is a random digit-dialed telephone survey conducted annually to collect information on health risk factors present in residents 18 years and older.[6] A total of 1567 Wisconsin residents were surveyed in the 1993 BRFSS. The participants were asked "Have you smoked at least 100 cigarettes in your entire life?" and "Do you smoke now?" For this analysis, current smokers are defined as persons who have smoked at least 100

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Percentage of current smokers and percent of smokers wanting and trying to quit by selected characteristics, Wisconsin 1993.

		% Current smokers	% Smokers wanting to stop smoking	% Smokers able to quit for at least one day in past year
Region:	South	23	77	59
	Southeast	22	73	60
	Northeast	24	85	74
	West	24	84	47
	North	24	90	72
Urban/Rural:	Urban	23	78	64
	Rural	24	84	59
Sex:	Male	23	79	58
	Female	23	80	66
Age:	18-34 yrs	27	81	66
	35-54 yrs	27	80	57
	55+ yrs	13	73	63
Educational Level:	Elem. School	7	85	85
	Some High School	43	76	54
	High School	27	80	61
	Some College	22	83	67
	College	13	74	62
Race:	White	22	79	62
	Non-White	29	80	65
Marital Status*:	Married	20	79	57
	Unmarried	28	80	68
Children:	None	22	79	62
	1 or More	25	80	63
Heavy Drinkers**:	yes	42	79	54
	no	22	80	63
Cigarettes/Day:	1-10	100	85	81
	11-20	100	79	56
	21+	100	72	31
Total:		23	79	62

* Married = respondents who are married or living with someone
Unmarried = respondents who are divorced, widowed, separated, or never married
** Heavy Drinkers = drinking 60 or more drinks per month

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cigarettes in a lifetime and who also currently smoke. By this definition, 365 (23%) respondents were classified as current smokers.

The current smokers were then asked the following two questions relating to smoking cessation: "Would you like to stop smoking?" and "During the past 12 months, have you quit smoking for one day or longer?" The responses to these questions were cross-tabulated by the following patient characteristics: region of residence in Wisconsin (south, southeast, northeast, west, and north), urban or rural residence, sex, age (18-34 yrs, 35-54 yrs, and 55+

yrs), educational level (elementary school, some high school, high school, some college, and college), race (white and non-white), marital status, having children, alcohol use (drinking 60 or more drinks per month), and number of cigarettes smoked per day (1-10, 11-20, and 21+). Tabulations were performed with SAS. Responses were weighted to adjust for the cluster design of the survey.

Results

The overall smoking rate in Wisconsin is 23%, with substantial differences found among several of the demographic groups. Those aged 54 years and less smoke more than those 55 years and older, non-whites smoke more than whites, unmarried individuals smoke more than married individuals, and heavy drinkers smoke more than those without a drinking problem (Table).

A substantial majority (79%) of smokers in Wisconsin expressed a desire to quit smoking, and 60% reported having quit smoking for at least one day in the past year. Similar high rates of wanting to quit and having quit for a day or more were found in all of the demographic subgroups (Table).

While the desire to quit smoking was comparable among smokers grouped by number of cigarettes smoked per day, there was an appreciable difference in their ability to quit smoking for at least one day in the past year; those smoking fewer cigarettes per day had greater success in quitting smoking for at least one day than those who smoked more. The group smoking 1-10 cigarettes per day have a rate of ability to quit of 81%, those smoking 11-20 cigarettes per day have a rate of 56%, and those smoking 21+ cigarettes per day have a rate of 30%.

Discussion

Most smokers in Wisconsin want to quit and have tried to quit in the past year. Based on the current census, an estimated 800,000 smokers in Wisconsin would like to quit and 700,000 are actively trying to quit. It is remarkable that this desire to quit is seen regardless of the smoker's sex, age, educational level, race, alcohol use, or other characteristics. Heavier smokers are just as likely to want to quit but were less likely to have tried quitting for at least a day in the past year. These results have important implications for physicians and public policy makers in Wisconsin.

The uniformly high rate of smokers who want to quit should encour-

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age physicians to discuss smoking cessation with all of their patients who smoke. Physicians are not imposing their values on recalcitrant smokers. In most cases they are assisting patients who want to address one of their most important health concerns.

At the same time, the high proportion of smokers who tried to quit in the past year, but ultimately failed, provides further evidence of the addictive power of nicotine and the difficulty in quitting smoking. The focus of this analysis on individuals who were still smoking at the time of the interview should not convey the impression that it is impossible to quit. The 1990 Report of the Surgeon General shows that the quit ratio, which is the proportion of smokers who have become former smokers, has steadily increased since the 1960's.[7] Numerous studies have demonstrated the effectiveness of physicians in helping their smoking patients quit.[8,9]

Dr Michael Fiore has called upon clinicians to expand vital signs to include smoking status, so that all patients are asked about tobacco use at every clinic visit.[10] The following simple 3-minute intervention by physicians in any outpatient setting is recommended by the National Cancer Institute[11]: 1) ask about your patients' smoking habits; 2) advise the smokers to stop; 3) assist the patients in quitting; and 4) arrange follow-up visits.

These findings are consistent with other research on smoking cessation[12] and support public policy initiatives to reduce smoking. They clearly show the importance of preventing children, adolescents and young adults from starting the highly addictive habit of smoking. They suggest that educational campaigns about the harms of smoking have succeeded in convincing smokers that they should quit. They may also explain the widespread acceptance of policies making it expensive, and often difficult or embarrassing to smoke; less than 5% of Wisconsin adults are smokers who do not want to quit.

The challenge now is to provide support and assistance to the 80% of smokers who express a desire to quit, and particularly to the 60% who have taken active steps to quit smoking and have had temporary success in their efforts. Physicians have a key role in meeting this challenge. Insurance and reimbursement policies should cover these costs, and promote physician involvement in this important public health problem.

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Compliance with Wisconsin Statute 134.66 regulating cigarette vending machines, Wood County, Wisc, 1993-95

Karen A. Kolpien, BA, and MaryAnn T. Lippert, MS, Marshfield

Vending machines are a significant source of cigarettes for youth. The purpose of this study was to determine if retailers with cigarette vending machines on their premises are complying with Wisconsin law designed to prevent youth from purchasing. Three cigarette vending machine site inspection surveys were conducted in Wood County during the period of 1993 to 1995. Results of the three site inspections showed that 4%, 29% and 15% of machines were in complete compliance with Wisconsin law. The most common reason for non-compliance was the lack of an appropriate warning sign. It is recommended that vending machine compliance data be included in future undercover buying operations, and suggested that the only vending machine regulation that can prevent youth access to cigarettes is one that bans cigarette vending machines. *Wis Med J.1995;94(11):621-624.*

Introduction

Cigarette smoking kills nearly 8,000 Wisconsin residents annually.[1] The prevalence of smoking among adults in Wisconsin declined between 1985 and 1993.[2] However, data on smoking among youth show that use rates are not decreasing, and may, in fact, be increasing.[3] Despite Wisconsin laws prohibiting the sale of cigarettes to persons under age 18, it was estimated that over five million packs of cigarettes were illegally sold to children in the state in 1991.[4] Undercover buying operations conducted in 1994 and 1995 indicate that youth in Wisconsin are able to obtain cigarettes from 24% - 92% of the time.[5]

Previous research has documented that vending machines are a significant source of cigarettes for youth.[6-8] Thirty-nine states, including Wisconsin, impose restrictions on the sale of tobacco through vending machines.[9] The intent of these laws is to prevent youth from purchasing tobacco through such machines. Wisconsin law (statute 134.66) restricting the sale or gift of cigarettes or tobacco products has three provisions relating to vending machines:

- A vending machine operator shall attach a notice in a conspicuous place on the front of his or her vending machines stating that the purchase of any cigarette or tobacco product by a person under the age of 18 is unlawful under s. 48.983 and that the purchaser is subject to a forfeiture not to exceed $25.
- The vending machine is in a place where it is ordinarily in the immediate vicinity, plain view and control of an employee.
- The vending machine is in a place where it is inaccessible to the public when the premises are closed.[10]

Previous research has looked at the posting of state-mandated warning signs for both over-the-counter and vending machine cigarette outlets in combination with an undercover buying operation.[11,12] In our review of the literature, we were not able to identify any published assessment of compliance with all provisions of state cigarette vending machine laws.

The purpose of this study was to determine if retailers with cigarette vending machines on their premises are complying with Wisconsin Statute 134.66.

Methods

As a part of the Tobacco-Free Central Wisconsin Coalition work plan funded by the Governor's Cancer Control Initiative, we chose to assess compliance of cigarette vending machines in Wood County.

A classification list of probable types of locations for cigarette vending machines was drafted. Telephone calls were made to retailers within those types of locations and employees and managers were asked "Do you have a cigarette vending machine?" to determine the location of the machines.

A data form was designed to record information gathered during a site inspection of each retail outlet to determine compliance with Wisconsin Statute 134.66. Information collected included: type of vending machine (tobacco only, tobacco and snacks, and other); cost of one pack of cigarettes; assessment of the level of accessibility when the premises are closed; assessment of presence or absence of an employee or work station in the immediate vicinity and in direct line of sight of the vending machine; and, the presence or absence of the appropriate sign as specified in the statute. Any other warning signs observed (i.e. Surgeon General's warning, tobacco industry signs such as "Support the Law") were noted on the data form. A comment section was included to note unusual circumstances or other relevant data.

Cigarette vending machine site

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Ms Kolpien is community coordinator and Ms Lippert is manager of community health programs and both associated with the Marshfield Medical Research Foundation, Marshfield, WI. Reprint requests to: Karen Kolpien, 1R-4, Marshfield Medical Research Foundation, 1000 N Oak Ave, Marshfield, WI 54449, 715-389-4147 or 715-445-2372.
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Continued from preceding page
inspections were conducted three times between 1993 and 1995 by staff and volunteers of the Tobacco-Free Wood County Coalition, a committee of the Wood County Partnership Council. The first site inspection of cigarette vending machines was completed in July 1993. Following the inspection, the results were mailed to all sites inspected along with an appropriate sign as specified in Wisconsin Statute 134.66.

In June 1995 we attempted to conduct a follow-up site inspection of all locations surveyed in 1993. Some locations were not included in the 1995 site inspection because they had gone out of business or had removed their cigarette vending machine. In addition, we learned of new retailers which had either been missed, added a cigarette vending machine or had opened since 1993. Methods similar to those used in 1993 were undertaken to identify new locations, and a third site inspection was conducted on those locations in July 1995.

Table 1--Location of vending machines inspected

Type of Location	1993 N = 46	1995 Follow-up N = 29	1995 New locations N = 25
Bar/Restaurant	18 (39%)	13 (44%)	4 (15%)
Campsite	2 (4%)	1 (3%)	0
Golf Course	3 (7%)	2 (7%)	0
Hotel/Motel	4 (9%)	2 (7%)	0
Restaurant	7 (15%)	3 (11%)	0
Bar Only	9 (20%)	8 (27%)	21 (80%)
Other	3 (7%)	0	0

Results

In 1993, 58% (27/46) of cigarette vending machines in Wood County were located in bars or bar-restaurants. In 1995, this increased to 85% (46/54) located in bars or bar-restaurants.

In 1993, 44 (96%) of the 46 sites were not compliant with the state law, defined as compliant with all three statutory criteria. Of these 46 that were surveyed in 1993, in 1995, 21 were still not compliant. Thirteen vending machines had been removed (2 citing reasons that the building was now smoke-free , 2 citing that the machines were difficult to monitor, one cited no sales, eight gave no explanation). Three sites had gone out of business, and one was lost to follow-up.

The difference in compliance rates between 1993 and the 1995 follow-up was directly the result of an increase in compliance with required signage. In 1993, only 4% of machines had an appropriate warning sign, while in 1995, 29% of machines posted an appropriate warning sign.

The 1995 survey of newly identified vending machines found 15% to be in compliance with Wisconsin law. Ninety-six percent of machines were inaccessible during non-store hours, and 73% were in plain view of an employee at a cash register, but only 4 or 15% had an warning sign.

Discussion

The purpose of this study was to determine if Wood County, Wisconsin retailers with cigarette vending machines on their premises are complying with Wisconsin Statute 134.66. Our results indicate that the majority of retailers were not compliant at the time of either the 1993 or 1995 site inspections.

The most common violation in our study was the lack of an appropriate warning sign as specified in Wisconsin Statute 134.66. The fact that results and an appropriate sign were sent to all locations after the 1993 site inspections, may explain why the follow-up data from 1995 has a higher rate of compliance with the signage requirement.

Our results indicate a lack of responsibility on the part of retailers to monitor signage and location of cigarette vending machines. Considering this situation, it is not surprising that undercover buying operations in Wisconsin have higher purchase rates for vending machines than over-the-counter sales. The average over-the-counter purchase rate among seven community coalitions during 1993 through 1995 was 33%. The average vending machine purchase rate was 69% with one rate of 30%; others ranged from 53% to 92%.[5]

Our data, together with results from other studies, creates an opportunity to consider policy change related to youth access to cigarettes. Interest generated by Wisconsin Project ASSIST (American Stop Smoking Intervention STudy) and local tobacco-free coalitions has led to an increase in undercover buying operations, particularly those targeting over-the-counter sales. Since municipalities are becoming increasingly willing to issue citations, the over-the-counter purchase rate will in all probability decline. Thus, vending machines will increase as a source of supply for both youth experimenting with smoking and youth who are regular smokers.

Given that other evidence has indicated that signage alone is insufficient to stop youth from purchasing,[11,12] the other two provisions of Wisconsin Statute 134.66 become very important, suggesting that undercover buying operations may be another way of collecting information to determine if this law is fulfilling its intent. We recommend that other tobacco control advocates in Wisconsin survey vending ma-

Table 2--Cigarette vending machine compliance with Wisconsin Statute 134.66

Criteria	1993 N=46	1995 follow-up N=29	1995 new locations N=26
Inaccessible when premises closed	41 (89%)	27 (93%)	25 (96%)
Immediate vicinity of employee	23 (50%)	17 (58%)	19 (73%)
Warning Sign/Wisconsin Statute	2 (4%)	8 (29%)	4 (15%)
Complete Compliance	2 (4%)	8 (29%)	4 (15%)

chines in future undercover buying operations, and collect data on compliance with signage and location criteria as stated in the Wisconsin law.

The intent of cigarette vending machine laws is to prevent youth access to cigarettes through such machines. Our study shows that the majority of retailers in Wood County are not complying with the Wisconsin law specifying signage and location. Some states and municipalities have adopted stronger legislation which restricts cigarette vending machines to "adult only" locations or requires the use of locking devices. Research has demonstrated that youth are still able to purchase cigarettes from vending machines despite these restrictions.[13,14] The only vending machine regulation that can prevent youth access to cigarettes is one that completely bans cigarette vending machines. A concise discussion and thorough bibliography on this issue can be found in the Institute of Medicine publication, *Growing Up Tobacco Free*.[15]

Acknowledgements

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Wisconsin public opinion regarding clean indoor air policies

Richard Yoast, PhD, and Patrick Remington, MD, Madison

Over the past several decades, clean indoor air policies restricting smoking in public places have been enacted in communities throughout the United States.[1] The purpose of this report is to review recent public attitudes concerning these policies, from a representative sample of youth and adults in Wisconsin.

The Wisconsin Division of Health, in collaboration with the American Cancer Society, participates in the American Stop Smoking Intervention Study (ASSIST) Project, a 7-year project funded by the National Cancer Institute.[2] As part of this study, the National Cancer Institute sponsored surveys of tobacco use and attitudes during the Current Population Surveys, conducted by the U.S. Census Bureau in September 1992 and May 1993. The Wisconsin survey sample included 3,844 adults aged 20 and over, and 294 youth ages 15-19. The interviews occurred in person (25%) and by telephone (75%). The survey addressed several areas: population characteristics (age, gender, race, smoking status and behaviors), worksite policies, and attitudes about smoking restrictions in various sites.

Smoking at home. Two thirds of Wisconsin adults restrict smoking in their homes, including one third who totally prohibit it. Almost half of the "never smokers" do not allow smoking at all, while almost two-thirds of "current smokers" allow smoking anywhere. However, even three out of ten "current smokers" restrict where, when and/or if smoking can occur in their homes.

Smoking in the workplace. Two out of ten adults, and almost three out of ten young adults (ages 15-24) work at places where there are no smoking restrictions. Total worksite smoking bans cover 45% of all adults, and another 19% work where

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Wisconsin public attitudes regarding clean-indoor air policies, Current Population Survey, Wisconsin, 1992-93.

Attitudes	All Adults Age 20+ (N=3,844)	Adult Smoking Status Current (N=996)	Former (N=999)	Never (N=1,849)	Youth Age 15-19 (N=294)
Smoking in home					
Not allowed	36%	7%	39%	49%	36%
Some places/times	31	28	33	32	27
Anywhere	33	64	28	19	36
Workplace - indoor					
Not allowed at all	56	27	60	69	46
Allowed in some areas	40	63	37	29	48
Allowed in all areas	4	9	3	1	4
Restaurants					
Not allowed at all	40	12	45	53	36
Allowed in some areas	55	78	50	45	58
Allowed in all areas	4	9	4	2	6
Bars and cocktail lounges					
Not allowed at all	20	3	22	28	11
Allowed in some areas	45	38	43	49	52
Allowed in all areas	34	59	33	22	36
Indoor Shopping Malls					
Not allowed at all	53	31	55	64	46
Allowed in some areas	41	58	40	33	46
Allowed in all areas	5	11	4	2	8
Indoor Sporting Events					
Not allowed at all	67	46	72	75	70
Allowed in some areas	28	42	23	22	22
Allowed in all areas	5	11	4	2	7

smoking is allowed in some public but not in any work areas. Almost all Wisconsin adults (95%) think that worksite smoking should be restricted; a majority (56%) think it should be totally banned. Among current smokers, one quarter of whom work in places where smoking is allowed everywhere, almost three out of ten would like to see a total ban, and another six want it restricted. Only 4% of current smokers think smoking should be unrestricted at work.

Smoking in public places. Large majorities of adults support smoking restrictions in restaurants (95%), bars and cocktail lounges (65%), indoor shopping malls (94%), indoor sporting events (94%) and hospitals (98%). This includes majority support for total smoking bans in indoor malls (53%), indoor sporting events (67%) and hospitals (72%). Current smokers show support for smoking restrictions in all of these venues with greatest support for total smoking bans in shopping malls (31%) and indoor sporting events (46%). Although one third of smokers would allow smoking in all bar and cocktail lounge areas, 41% support restrictions. Youth attitudes, compared to adult, indicate less support for total smoking bans, more support for some smoking restrictions, and a similar lack of support for unrestricted smoking.

Discussion

These surveys demonstrate widespread support for clean-indoor air policies in Wisconsin. Two-thirds of Wisconsin adults--including one-third of smokers--have taken steps to prohibit or restrict smoking in their homes. Over half of adults--including one-quarter of smokers--want smoking to be completely banned in the workplace. These opinions likely result from awareness of the harmful effects of smoking, and among smokers, that such policies might assist them in their efforts to quit smoking.

Wisconsin state law currently prohibits smoking in hospitals, doctors' offices, buses and taxis, day care centers and public schools and restricts smoking in restaurants, many indoor areas and office workplaces and retail establishments. Local ordinances, voluntary private and administrative policies, have also resulted in smoking bans in many state, county and municipal buildings, public and private institutions of higher education, shopping malls, sports facilities, restaurants, and worksites. However, substantial numbers of workers in manufacturing, assembly and service work remain exposed to envi-

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ronmental tobacco smoke. Non-smokers are exposed to tobacco smoke in numerous public and private facilities where smoking is unrestricted or limited to certain areas but occurring in the same air ventilation system.

These survey data indicate overwhelming support for restrictions on smoking in the workplace, hospitals, indoor shopping malls and indoor sporting events. Under current state law, only hospitals are required to be smoke-free. The survey indicates very little public support for unrestricted smoking in any of these areas and indicates widespread support, even among smokers, for greater restrictions than are currently mandated by law. Although citizens spend only limited amounts of time in the non-worksite locations, it should be noted that all are also indoor worksites in which continued exposure to environmental tobacco smoke present extra dangers to workers. They are also places which many youth and women of child-bearing age frequent and need to be protected from environmental tobacco smoke.

An area of frequent conflict in local, state and national debates about clean indoor air involves policies concerning restaurants and bars. Although many Wisconsin restaurants have voluntarily gone smoke free in recent years (over 700 according to the Wisconsin Initiative on Smoking and Health), only the city of Madison has a total ban. However, one issue often debated is whether bars, taverns and cocktail lounges should be exempted from restrictions. This survey indicates majority support for restaurant smoking restrictions and a sizeable number who want total bans. Despite arguments made for no restrictions in bars and cocktail lounges, this survey shows widespread public support among smokers and non-smokers for at least restricting smoking in these locations.

In conclusion, public support for restrictions on smoking and for clean indoor air is widespread and goes far beyond current public policies. Even among smokers, there is strong support to reduce the impact of smoking on themselves and others. The desire to restrict smoking is expressed in citizens' positive attitudes towards reducing or eliminating smoking private settings they control and in support of even greater restrictions in public and private settings.

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Editorial Note: This study shows widespread support for strict clean-indoor air policies in Wisconsin. Despite the tobacco industry's fear of "government tobacco police," Wisconsin needs to continue the progress it has made in providing clean indoor air for every person in the state. Physicians need to strongly support clean indoor air policies in their communities. These policies will provide a strong message to children, and provide an environment to help adult smokers who are trying to quit. T.M.❖

Maternal smoking data is released

MATERNAL SMOKING IN Wisconsin is the focus of the most recent *Health Data Review*, published by the Wisconsin Center for Health Statistics. The report found that older women were less likely to smoke during pregnancy than younger women and maternal smoking varies by insurance status. The findings suggest ways to focus efforts to decrease smoking among women of child-bearing age in the state. For a copy of the publication or more information, call or write Patricia Guhleman (608) 267-5221 or Susan LaFlash (608) 266-8927 at Wisconsin Division of Health, Center for Health Statistics, P.O. Box 309, Madison, WI 53701-0309.

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TQM & CQI: Practice panacea or just another bowl of alphabet soup?

George W. Kindschi, MD, MS, Monroe

For decades, the word "quality" has been bantered about by the medical profession and, inevitably, it has taken on different meanings to different people. To the patient it may mean spending less time in the waiting room or more time with the doctor; to the physician it may mean the rapid return of laboratory test results and X-ray reports or the ease of obtaining specialty consultations; to the administrator it may only be represented by a positive bottom line. Quality in health care, like beauty, is very much in the eye of the beholder.

The basic concept of trying to measure "quality" in health care had its origins within the traditional approach to the practice of medicine. This was the time when each physician was totally responsible for the care of his or her patients. The actual quality of care was solely dependant on the physician's knowledge, skill, experience and judgement. If things went well, the physician was praised; if things went poorly, the full blame fell upon his or her shoulders. It was the patient and the patient's family who judged the quality of care that they were receiving.

As medical knowledge expanded and the practice of medicine became more sophisticated, informal peer review of medical care became the norm. Grand rounds, clinicopathologic conferences and, in private, the sometimes heated discussion of the management of individual cases evolved as forums for physicians to analyze and hopefully improve the quality of the care that they were providing. It was a good-old-boys-behind-closed-doors-educational approach to try to do a better job.

As regulatory agencies acquired more power, they began to require institutions to have formal review of surgical cases, transfusions, drug use, medical records, etc. These mandates forced hospitals to create numerous committees that systematically examined various facets of each physician's practice. No longer were physicians reviewed only by their peers: they were now reviewed by committees consisting of administrators, nurses, medical records personnel and members of any other department that believed that they were directly concerned with the evaluation of the quality of care. No longer could free-wheeling discussions of the diagnosis of disease or the treatment of patients be made within the privacy of a peer group. The discussion was now open to all. From this, the broad concept of total review of patient care emerged as the entity "Quality Assurance."

On the surface, Quality Assurance (QA) seemed to be a good way for an institution to ensure to the public that it was delivering the highest quality of health care to its patrons. Yet, in reality, QA programs have done little to *ensure* quality. Because of the presence of these QA programs, it seemed that every decision that a physician made in patient care might be subject to retrospective committee review. In fact, the very existence of these reviewing bodies began to create an atmosphere of fear and distrust among physicians. They questioned the right of lay personnel to criticize their practice and disliked this newer concept of "peer-review" especially when the reviewer was not trained in a like or similar specialty. This, coupled with the escalation of malpractice litigation, forced physicians into the uncomfortable mode of practicing defensive medicine: more lab tests, more X-rays, more consultations, and more referrals to specialists.

Does all this required review significantly improve the quality of care delivered to the patient? Probably not. Instead, we find essentially the same product being delivered to the public at a much greater cost to the provider and at a much greater price to the patient. Yet, the public would probably not be able to accept a health care system that did not, in some way, search for substandard care and take definitive action against transgressors. The days when "the doctor is always right" are gone and have been replaced by the days "the doctor had better be right or I'll..."

Both Continuous Quality Improvement (CQI) and Total Quality Management (TQM) started from very different traditions than did QA, and have very different assumptions. They originated from an industrial model based upon assembly line work where the job is repetitious and anonymous. In this arena there are no obligations between the employee and management, except for the worker to perform a routine job for a set salary as defined by management. In addition, there is no obligation between the worker and customer as long as the product passes minimal standards, also defined by management. All that is expected from the employee is that the job be done *as defined*, nothing more, nothing less. The customer is never known to the worker and the employer is only a faceless organization whose sole intent is profit.

The CQI/TQM challenge is to take these isolated, disinterested parties and build a team that is primarily concerned with producing a

top notch product or service. In the case of manufacturing, any advantages or disadvantages a product may have, as well as its actual quality, are easily recognized by consumers. Customer displeasure has an immediate impact upon sales. In the service industry, however, the quality of the product may often be judged by how it is presented to the consumer rather than by actual intrinsic value. In the case of health care, as in the case of manufacturing, the concept of quality can be, at least partly, equated to customer satisfaction.

In general, TQM/CQI have their basis on two broad assumptions: first, quality problems are system problems, not people problems, and, second, after a problem is anticipated or identified, a multi-disciplinary team is created to work on a solution with the idea of preventing the problem from recurring again in the future.

Can these basic principles of TQM/CQI actually be applied to health care? Yes, but with difficulty and with a format that differs from the industrial model. While the TQM/CQI principles are constant, each health care complex has its own unique characteristics, and each plan must be tailored to fit the real and perceived needs of the institution and its patients. And, most importantly, unlike industry where the raw materials are supposed to be uniform, it must be remembered that humans are not. Since patients and their problems are in fact the raw material for the health care industry, the services provided to them must be flexible enough to tolerate the non-uniformity in its patients, their illnesses and their families, so as to be able to provide uniform, high quality, service for all.

In his book *Out of the Crisis*, W. E. Deming outlined fourteen points that he believed necessary for the success of TQM/CQI in industry (table).

Points necessary for the success of TQM/CQI in industry.

1. Create consistency of purpose for improvement of product and service.
2. Adopt the new philosophy.
3. Cease dependence on inspection to achieve quality.
4. End the practice of awarding business on price tag alone.
5. Improve constantly and forever the system of service.
6. Institute training.
7. Institute leadership.
8. Drive out fear.
9. Break down barriers between staff areas.
10. Eliminate slogans, exhortations and targets for the work force.
11. Eliminate numerical quotas.
12. Remove barriers to pride of workmanship.
13. Institute a vigorous program of education and retraining.
14. Take action to accomplish the transformation.

It is obvious that some of these points do not directly fit into the service industry, but if taken as a whole, the philosophy of these fourteen points can be used to create a general outline for a successful TQM/CQI plan.

The first step is evaluation of the existing QA program with subsequent retention of any of its positive elements. Aberrations in care will still need to be investigated, evaluated and corrected as necessary. It must always be remembered that TQM/CQI is not an evolutionary product of QA; it is a different method of systems analysis directed at constant improvement process, not of exhorting people to work harder and do a "better" job.

Second, there must be an acceptance, a "buy-in," by *all* personnel at *all* levels of the organization: a total commitment to quality. The attitude of just coming to work, doing a job, collecting a paycheck, and going home must change into a personal desire on each employee's part to consciously think of how they might improve whatever product they make or whatever service they deliver. They must want to change form just being a cog of a wheel, to being a vital part of the development of a dynamically changing organization. They must know that their opinion counts; they must be given the latitude to explore changes without penalty for failure; they must be encouraged to think and leave robotics to robots. Few things can discourage innovation more than management's response to a suggestion or idea: "We already thought of (or tried) that."

Top and middle management must give up some of their decision making powers and allow those "lower" on the corporate ladder to become their own micromanagers. Empowerment is not an easy concept for many administrators at any level of management to accept. It is viewed as a loss of personal power and prestige, rather than as a method to improve quality. This monumental change in thinking and attitude may take a significant amount of time and this delay may be discouraging for all concerned. It may even tempt an alteration in the course of action or to just continue current QA programs and call them TQM/CQI programs. Yet, when the acceptance of this novel management technique begins to spread responsibility to lower management levels, the concept of the commitment to continually search for ways to improve the quality of a product or service will begin to become sec-

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ond nature to every member of the organization.

The third step actually occurs concomitantly with the second. This is the use of "quality teams" who not only attempt to solve systems problems but who also evaluate the smoothly running areas to see if any improvements could be made. The primary mission of these teams is improving the over-all quality of products or services rather than just rooting out problem areas.

The teams are composed both of people from within the area to be examined, as well as those from other areas with the health care institution. Also, as members of these teams, are "quality coaches," people well versed in the application of TQM/CQI but usually knowing little or nothing about the area being evaluated. A major objection to such teams, in fact, one of their great strengths: the presence of the team of people from outside the department being evaluated. Department members may ask, "How can someone from housekeeping know anything about laboratory turn-around time?" or "How can someone from dietary help streamline patient flow?" Perhaps these people won't be of help, but often their unbiased suggestions lead to discussions which in turn lead to ideas and innovations that might not ever have occurred to those close to the system.

Since these teams are evaluating systems and processes, not people, they usually gain the support of the personnel in the area being examined. This type of acceptance leads to cooperation and a greater willingness to act upon the suggestions of the team. Again, it must be emphasized, there must be no penalty for failure; if there is, it will stifle creative thinking and defeat the whole purpose of TQM/CQI.

What results should be expected if the program is successful? Usually the most tangible result is reduced costs. This is most commonly due to more efficient use of existing resources, reduction in errors and a decrease in rework. In his book, *Quality is Free*, Phillip Crosby states: "Quality is free. It's not a gift but it is free. What costs money are the unquality things - all the actions that involve not doing jobs right the first time." Yet, although free, quality is not without cost. Part of that cost is the courage to begin to create positive change. The savings, which soon out weight the costs, are in the efficiencies and positive attitudes created by this change.

The road to a successful TQM/CQI program in hospitals and clinics is not fully charted nor will it be the same route for every institution. But, by getting the full cooperation of all those who work there, and with the full and honest support of all levels of management, TQM/CQI can succeed - but everyone must *want* it to succeed.

Since TQM/CQI is not really a program but a process, its success will be self perpetuating, it will become a joy - not a job - it will be a source of pride for all. It cannot succeed, however, if it is only hollow words and pledges echoed in a TQM/CQI plan. It must be actions spread out over years with each individual employee a part of the process. It must be flexible enough to accommodate the variations among patients and their problems, but it still must conform to the rules and regulations of accrediting and licensing agencies.

It must be understood by all that these changes will take time and that TQM/CQI is not a quick fix. The changes must be fully supported by all levels of management; insincerity at the top is the kiss of death to any TQM/CQI program. It must also be wholeheartedly financially supported, believing that its success will more than cover the costs of implementation.

The application of the principles of TQM/CQI to medical practice will not create a problem-free environment. It will, however, allow the creation of a positive atmosphere where everyone has the same goal: to provide the highest possible quality of service both to patients and coworkers through constant evaluation of the processes through which the service is delivered.

TQM/CQI is neither a panacea for the medical practice nor a bowl of alphabet soup. It can't solve all the problems we face but it can help us change the way we approach them. TQM/CQI can give us a new, bright perspective on our much maligned industry. It will give us the ability to approach what we are doing with an earnest desire to turn out the best product or service that we can. In this light, "quality" becomes a very simple concept: it is an attitude.❖

Medical staff bylaws are violated by hospital's ICU restrictions

Patience D. Roggensack, Esq, Madison

On Sept 7, 1995, the Wisconsin Court of Appeals, District IV, decided that the Medical Staff Bylaws of Janesville's Mercy Hospital are a binding contract between the medical staff and the hospital; and that, by unilaterally enacting certain ICU Restrictions Mercy had breached its obligations to the 29 doctors who brought suit against the hospital.[1] In so doing, the Court relied heavily on a provision in the hospital's corporate bylaws that bound the hospital to the Medical Staff Bylaws when the hospital's Board approved them. The Court also relied on the hospital's requirement that the doctors who were granted medical staff privileges had to sign a statement acknowledging they had read the Medical Staff Bylaws and agreed to be bound thereby and on specific delegations of authority to the medical staff in the Medical Staff Bylaws. The Court of Appeals sent the case back to the trial court so the doctors could prove the amount of monetary damages the hospital's action caused.

As part of their initial claims, the doctors had also alleged that the hospital and its ICU director had intentionally interfered with their doctor-patient relationships. The Court of Appeals reversed Reserve Judge Callow's dismissal of these claims as well, saying that a reasonable jury could decide that both the ICU director and the hospital had acted in a tortious manner when the ICU Restrictions were put in place.

Mercy Hospital is the only hospital in Janesville. It is owned by Mercy Health System Corporation,[2] which is a direct competitor of the 29 doctors who brought the law suit. All of the doctors had medical staff privileges and had been credentialed to treat their patients in the ICU at the hospital. *None* of the doctors had ever had the care they delivered in the ICU questioned in any way. In fact, the hospital never claimed that any of the doctors were not fully qualified to care for their patients in the ICU.

The actions which gave rise to the doctors' claims began in March of 1994, when, at the suggestion of the ICU director, and without input from or the consent of the medical staff, the hospital told the medical staff that beginning on May 1, 1994, only a very limited number of doctors would be able to continue to direct the care of their patients in the ICU. The hospital's stated reason for the unilateral change was to improve patient care, notwithstanding the hospital's inability to identify even one instance of less than optimal care delivered by any of the doctors.

The doctors attempted to get the hospital to realize that the changes it had announced would actually *lower* the quality of care delivered[3] and to voluntarily to reverse its edict. However, when all efforts failed, they filed suit on April 30, 1994. A local Rock County Circuit Court Judge granted the doctors' request for a temporary restraining order, which initially prohibited the hospital from reducing the doctors' medical staff privileges. However, when Reserve Judge Callow took over the case, he vacated the temporary restraining order and, one week before the case was set to go to trial, he dismissed the entire lawsuit.

On appeal, the doctors argued that the Medical Staff Bylaws created a contractual relationship between the doctors and the hospital; and therefore, the hospital was not free to make unilateral changes in the privileges previously granted to the doctors. They also argued that their exclusion from the ICU was a form of economic credentialing which improperly interfered with their doctor-patient relationships. The State Medical Society of Wisconsin filed an *amicus curiae* brief in support of the doctors' position. The Court of Appeals agreed[4] with the doctors.

The case points up the importance of both individual physicians, and medical staffs in their entirety, being aware of the factors that should be present if they are to assure themselves that their medical staff bylaws do rise to the level of a contract, so they will have rights as well as responsibilities under them. Doctors should refuse hospital overtures to change bylaw provisions which currently state that: 1) the medical staff bylaws are the rules that govern the doctors who practice at the hospital; 2) the doctors are required continuously to meet standards and qualifications in the medical staff bylaws; 3) the doctors receive only those privileges stated in their individual appointment letters and the medical staff bylaws; 4) the doctors are required to read the medical staff bylaws and to sign a statement so acknowledging and agreeing to be bound by the terms of the medical staff bylaws; 5) the hospital must give the doctors due process hearings for any reduction, limitation or termination of their privileges; 6) the medical staff bylaws contain the procedures for

Continued on next page

Ms Roggensack is an attorney with the Madison law firm of DeWitt Ross & Stevens, SC, that represented the Doctors in their lawsuit.

Continued from preceding page
credentialing and transfers in patient care from one physician to another; and 7) hospital corporate bylaws that bind the hospital as well as the doctors to the medical staff bylaws once the hospital board approves them. Any proposed changes in these areas, and others too numerous to mention, should result in consultation by *independent*[5] counsel, who is familiar with the impacts that seemingly innocuous changes in medical staff bylaws can have on the rights of physicians and their ability to deliver quality care to their patients.

References:

1. *John A. Austin, M.D., et al. v. Mercy Health System Corporation, A/K/A Mercy Hospital of Janesville, Wisconsin, Inc.* No. 94-2905 (1995).
2. Mercy Health System Corporation changed its name from Mercy Hospital of Janesville, Wisconsin, Inc. after it purchased a large multi-specialty clinic, the Janesville Clinic, and changed its business from simply operating Mercy Hospital to operating primary care medical clinics, in addition to the hospital.
3. The ICU Restrictions contained a list of physicians who retained their ICU privileges. The list excluded many groups of physicians, *eg*, orthopedic surgeons, obstetricians, pediatricians, general internists and family practitioners.
4. On Oct 9, 1995, the hospital petitioned the Wisconsin Supreme Court to review the Court of Appeals Decision. It will probably be near the end of the year before the Supreme Court decides whether it will hear the case or send it back to Rock County for trial without further decision.
5. At trial, the hospital's attorneys who had participated in drafting and recommending changes to the Medical Staff Bylaws were the same attorneys who defended the hospital in court and vigorously argued that the ICU Restrictions had *not* reduced the doctors privileges and that the Medical Staff Bylaws, while binding the doctors, did not bind the hospital.❖

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The Hanlester decision: Intent is significant in anti-kickback law analysis

On April 6, 1995, a panel of the US Court of Appeals for the 9th Circuit issued its decision in the longstanding Hanlester series.[1] The court upheld the validity of the Medicare and Medicaid anti-kickback laws on constitutional grounds.

The court, however, found that physicians and others holding limited partner interests in laboratory joint ventures, who received indirect return on their investments by referring patients to those laboratories for services had not violated the anti-kickback statutes because they had not intentionally solicited or received remuneration for referrals.

In contrast, a marketing vice president, and the entities for which she was an agent, were found in violation of the anti-kickback statute for inducing referrals based on sales efforts that directly tied the laboratory limited partnership shares to referral requirements.

Background

The case began in 1989. Initially, the California US attorney rejected a request for criminal prosecution. The Office of the Inspector General of the Department of Health and Human Services (OIG) brought the first action in the case under its administrative exclusion authority to enforce the Medicare and Medicaid anti-kickback statutes.

The Hanlester Network had established three limited partnership joint ventures to own laboratories in California. The laboratories were operated through management agreements with Smith Kline BioScience Laboratories, through which Smith Kline received 76% of the net cash proceeds, with the remainder ultimately distributed to the partners.

The physician limited partners received their share of the overall profits from the laboratories, based on the number of limited partnership interests each owned. While the physicians were told that each laboratory's success generally depended on the referrals made by each physician, the physicians were not required to make referrals and neither the acquisition of the shares nor the receipt of profits depended directly on referrals.

The government's initial position--and its position before the Court of Appeals--was that the limited partnership and management arrangements were no more than "sham" operations, serving as mere mechanisms for the payment of funds to the limited partners for referrals. The government claimed that the arrangement constituted a knowing and willful violation of both the *offer or payment to induce referrals*[2] and the *solicitation or receipt of remuneration in return for referrals*[3] provisions of the anti-kickback statute. The claims were brought against the Hanlester Network, its officers, the limited partnership laboratories, and Smith Kline (Smith Kline quickly settled for $1.5 million).

The claims regarding the *offer or payment to induce referrals* focused on the actions and relationships between the Hanlester Network, its labs, and the physician limited partners. The claims regarding *solicitation or receipt of remuneration in return for referrals* were focused on the actions and relationships between the Hanlester Network, its labs, and the contract manager of the labs, Smith Kline. Exclusion from the Medicare and Medicaid payment systems was the government's goal. After already more than 300 pages of judicial decisions from prior proceedings, the 9th Circuit Court of Appeals reversed in part, affirmed in part, and added its decision to the Hanlester legacy.

Legal rulings

As a preliminary matter, the court ruled that the government need not prove the existence of an agreement to establish a violation of the anti-kickback statute. Upholding a position that has been widely criticized, the court ruled that it is not a requirement of the anti-kickback statute--or any other applicable law--to prove violation that the government prove an agreement exists among the alleged participants in the scheme to refer Medicare- or Medicaid-related business.

Under the ruling, the payor and the receiver of remuneration for Medicare or Medicaid referrals need not share the same understanding of the referral transaction--there need be no referral agreement--for either the payor or the receiver to violate the law. The actions and individual intentions of the payor or the receiver are to be independently examined to determine if the prohibitions of the statute have been violated. Depending on the circumstances, in the same transaction a payor could be found to have violated the law, while a receiver is not.

The court's decision also includes several interpretations that clarify certain elements of the anti-kickback prohibition. The court agreed with the government's interpretation that the phrase "to induce" from the payor statute means "an intent to exercise influence over the reason or judgment of another in an effort to cause the referral of [Medicare or Medicaid] related business."[4] While the interpretation may not be particularly enlightening, it does reiterate that something more than mere encouragement is required to find inducement. How much more remains unclear and will depend on individual facts and circumstances.

In the most significant finding of

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the decision, the court interpreted the knowing and willful element of the statute to mean the government must prove that alleged violators "(1) know that [42 USC §§ 1320a-7b] prohibits offering or paying remuneration to induce referrals, and (2) engage in prohibited conduct with the specific intent to disobey the law."[5]

This interpretation places a significant burden on the government to prove its case, requiring sufficient evidence of actual knowledge of the anti-kickback prohibition and specific intent to violate that prohibition.

Although this interpretation of the meaning of knowing and willful is a partial victory for providers, it may ultimately not stand. The OIG has requested reconsideration of this portion of the court's decision by the full 9th Circuit bench.

The court's discussion

The court's discussion of several of the facts underlaying the government's claims are instructive for evaluating compliance with the anti-kickback provisions. The court found that the obligations established by the limited partnership share profit distribution structure alone was not sufficient to prove an offer or payment to induce referrals. The court was not persuaded to find a violation by the facts that the limited partner structure was designed to significantly benefit an investor who also was in a position to refer business to the labs or that the success of the labs depended on the referrals from the limited partners. The reason for the court's lack of concern for this structure were as follows:

- Although substantial cash dividends were paid, they were paid based on the limited partner's ownership of partnership shares and not on referrals, and regardless of whether referrals to the laboratories were made.
- "The fact that a large number of referrals resulted in the potential for a high return on investment, or that the practical effect of low referral rates was failure of the labs, is insufficient to prove that appellants offered or paid remuneration to induce referrals."
- There was evidence which showed that the Hanlester Network desired to comply with the law and structured its business operation in a manner it believed to be lawful.[6]

The court found no improper activity based on any of these facts, including the fact that the Hanlester Network and its labs "...offered physicians an opportunity to profit *indirectly* from referrals when they *could not* profit directly."[7]

Apparently the court was not troubled by the provisions of the management agreement between the Hanlester Network, its labs, and Smith Kline. The court found substantial evidence that the Hanlester Network and its laboratories benefitted significantly from the relationship with Smith Kline: They received 24% of net profits from Smith Kline's contract management of the labs; they used of Smith Kline's name and reputation; and Smith Kline advanced payments and assumed operational risks.

The court, however, did not find that these facts amounted to an intentional solicitation or receipt of remuneration for referrals. In reaching its decision that the benefits of this relationship were not improper, the court also noted that there was evidence that the parties did not conceal the ultimate flow of payments from Smith Kline to the physician-limited partners and that no direct payments were made by Smith Kline to the Hanlester Network (all payments flowed from the labs to the Smith Kline in the form of its management fees).

The court did find evidence of a violation of the anti-kickback statute in the actions of Hanlester Network's vice president of marketing. As evidence of the violation, the court noted that the vice president of marketing took action beyond the Hanlester Network-prepared private placement memoranda (apparently acceptable to the court) that was to be used as the only sales material used in connection with the limited partnership share sales. The vice president of marketing proceeded as follows:

- Marketing efforts implied that eligibility to purchase limited partnership shares depended on an agreement to refer Medicare- and Medicaid-related business.
- Prospective limited partners were told that the number of shares they would be permitted to purchase in the laboratories depended on the volume of business that they referred to the laboratories.
- Statements were made that limited partners who did not refer business would be pressured to leave the partnerships.
- Prospective investors were told that return on investment was virtually guaranteed.

The court found these actions and statements by the vice president of marketing to constitute offers to induce referrals.

Since the anti-kickback law is intent-based, the court's decision went on to determine whether the offers to induce referrals that were identified were in fact *knowing and willful* under the court's interpretation. Concluding that the violation was in fact *knowing and willful*, the court gave little guidance regarding the facts that support its conclusion. The court's entire discussion of the issue is the following:

> [The vice president of marketing's] representations to limited partners exceeded the parameters of the private placement memoranda issued by the Hanlester Network. Her actions reflect both knowledge that her conduct was unlawful, and a specific intent to disobey the law. Her conduct was knowing and willful.[8]

Although the court established a rigid *knowing and willful* standard, including actual knowledge of what the law prohibits, the court was also able to find a knowing violation without the discussion of any direct evidence that the vice president of marketing had specific knowledge of the anti-kickback prohibitions. Circumstantial evidence was apparently sufficient to support that finding. To complete its analysis, the court applied *respondent superior* principles to these facts. Under these agency laws, the organizations for which the vice president of marketing was an agent--the Hanlester Network and the laboratories--were also found to have violated the anti-kickback statute.

Conclusion

The current Hanlester decision is the most significant anti-kickback decision issued within the last several years.

The court's interpretation of the *knowing and willful* element, if upheld through further appeals, will leave the government with a very difficult burden when seeking to prove a violation of the anti-kickback law.

If appeals by the government are not successful, legislative efforts by the government should be anticipated to overturn the court's interpretation. The outcome of such efforts are difficult to predict, but Congress in the past has not been pro-provider in issues related to kickbacks or fraud and abuse.

Given the higher burden placed upon the government by the current Hanlester decision to prove a violation of the law, and the continued uncertainty from the provider perspective on the exact meaning of the court's decision, the court's decision may have satisfied no one. Nevertheless, providers who have been acting in good faith to seriously promote compliance should be strongly encouraged by this decision - at least until the appeals are complete.

References

1. Hanlester Network v. Donna Shalala, No. 93-55351 (9th Cir., April 6, 1995), 1995 LEXIS 7612.
2. 42 USC § 1320a-7b(b)(2).
3. 42 USC § 1320a-7b(b)(1).
4. Hanlester Network v Donna Shalala, No. 93-55351, slip op. at pp. 18-19.
5. Id. p. 24.
6. Id. p. 20.
7. Id. pp. 19-20.
8. Id. at page 24.❖

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CD Rom Review
Clinical Dermatology Illustrated: A regional approach

R. Zorba Paster, MD, Oregon

Featured title:	Clinical Dermatology Illustrated: A regional approach
Publisher:	CMEA Multimedia Group, 4029 West George Street, Chicago, IL 60641, Telephone: 1-800-227-2632
Rating:	
Audience:	Family physicians, internists, pediatricians, ER physicians and anyone else who actively is engaged in primary care.

HAVE YOU EVER HAD a patient walk into your office to show you a rash and you don't have the foggiest idea what the rash is?

What sounds like a first day clerkship experience is, in fact, a not so uncommon primary care quandary. As the first one in the trench to look at a rash, you may find yourself thumbing through a derm atlas trying to match the right color plate with the right patient.

At times like this, wouldn't you welcome a neat, easy, fast method of coping with this recurrent pesky problem? Would you like to be able to have immediate access to a stock resource of photos and ideas for treatment that would aid you in making the diagnosis and developing your treatment plan? As an added bonus, would you like to be able to print out on-the-spot an educational handout for your patient to take home?

If you answered any of the above questions in the affirmative, then I invite you to read on about a dynamite CD ROM.

Getting started with CD Rom

For this program you'll need:

1. A personal computer (PC)--it can be IBM-compatible or a Macintosh--with a CD ROM and at least 4 Meg of RAM (that's a measurement for memory).
2. A SVGA or similar card which will show 265 colors or more.
   P.S. *If you're new at this technology, ask around and shop. A good PC clone system with a quad-speed (i.e. fast) CD ROM sells at discount stores for a bit more than $1400.)*
3. A printer to provide patient handouts.

Accessing the program

After punching past the first title page (a kinda nice one) you will arrive at the main section of the program. Punch introduction and you'll get a dandy 3 minute diatribe filling you in on what you're about to experience. Then you have several options:

1. You can click on a little miniature person's arms, trunk, feet, head...anywhere and *pop!* a list of possible diagnoses scrolls up. Then scroll through the list and find what you think might fit the patient. For example if you click on the computer person's head, the list that pops down is--seborrhea dermatitis, psoriasis, tinea capitus, head lice, alopecia and *other* - (tumors, lumps, and marks). Now the real fun begins...
2. Click on the diagnosis (for our example, you'd click on *seborrheic dermatitis)* and out comes a plethora of information:
   - color photos (often more than one shot) of the disease;
   - a short 1-2 minute dissertation on the diagnosis;
   - a list of treatment modalities; (You can print this list out if you wish so you can sort through it and attach it to the patient's chart;

   AND...best of all...
   - A patient print out explaining the disease and what they should do to treat it, to avoid it, etc.
3. Another way at this data is to punch the search button and type the diagnosis. You'll get to the same material, perhaps even quicker.
4. EXTRA BENEFIT!!!
   *You can *hot key* within the text and travel from one topic to another. To *hot key* means that you put your mouse on the word--usually in a different color or bolded or underlined--and by clicking the mouse button you will change to an associated topic. For example if you're in seborrheic dermatitis, on the treatment section and *hot key* at <u>*SHAMPOOS*</u>, you'll be in the shampoo section with treatment suggestions, and explanations about shampoos. Everything you wanted to know about shampoos by the touch of a *hot key.*

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The program has 60 short audio lecture segments, 340 photos, an easy-to- use search engine (easy that is for anyone who has used a Mac or knows Windows) and an easy-to-see graphical user interface. In addition, you can obtain 20 hours of CME category credit for anyone willing to answer and send in those questions.

For another $100, you can buy a bundle that includes the CD ROM and a VHS video--2 hours of dermatology procedures illustrated for the non- dermatologist.

Conclusion

I *like* this title. I find derm a fun thing in my practice but sometimes I'm stumped. I found the patient handouts to be very, very interesting and useful in my practice. The verbal discussions were OK when I had the time and easy to shut off when I didn't. I highly recommend this title for any doc who sees the skin and treats the patient (gave it almost the top at 4-1/2 stars).❖

Homeowners insurance basics

by Michael J. Dolan, CLU, ChFC, Madison

. . .Your fireplace throws off a spark, setting off a living room fire and destroying newly-purchased furniture.

. . . A burglar ransacks your home, vandalizing what he doesn't steal.

. . . The mail carrier slips on ice on your front walk, is injured, and sues.

. . . A windstorm uproots a tree; it lands on your porch roof, causing massive damage.

. . . Your son is walking the dog, several blocks from home, when the dog breaks loose and bites a passerby.

These events have just one thing in common (besides raising your stress level): Protection against financial loss stemming from any one of them is provided in a homeowners insurance policy.

All homeowners insurance policies, although they vary in accordance with state laws, the issuing company and the coverage you choose, have certain elements in common. All include both property insurance, usually with a $250 deductible provision, and personal liability coverage, with no deductible. All cover:

- The house itself, in the amount you designate; a minimum of at least 80 percent of the house's replacement value is desirable. If your house is not insured to 80 percent of its replacement value, then you will be reimbursed only for the actual cash value of depreciated property at the time of loss. With 80 percent coverage, you'll be sure of full reimbursement for a partial loss, without regard to depreciation, up to the full amount of the policy.
- Other structures on the same property, such as a garage or tool shed, to 10 percent of the value of the house.
- Personal property, the general contents of your home, usually up to half the insured value of the house; you can arrange for more. (There is also a strict dollar limit on specific valuables, such a furs and jewelry; if you own such property you may want a personal articles floater as well.)
- Additional living expenses, should you have to house your family elsewhere while repairing damages caused by an insured incident.
- Losses of personal property away from home, usually up to 10 percent of the policy's value. This coverage applies to items you take on vacation as well as to possessions in a college dormitory, as long as the student has resided there within the past 45 days.
- Personal liability, in case someone slips on your icy sidewalk or trips over a garden tool, at a standard minimum of $100,000; liability coverage may be increased by paying an additional premium.
- Medical payments to people injured on your property, without regard to fault, up to $1,000 per occurrence; this amount, too, may be increased.❖

Michael J. Dolan, CLU, ChFC

Dolan is vice president and chief operating officer of SMS Insurance Services and a member of the National Association of Life Underwriters.

Imagine being born with spina bifida and having 10 operations by the time you're 10 years old. It's enough to make anyone forget what it's like to be a kid. That's why Easter Seal camp was the perfect thing for Jimmy. It gave him the opportunity to be a kid. To do all the things that the average kid takes for granted. And according to Jimmy, who's now a successful, happily independent adult of 27, it was the chance of a lifetime. That's the kind of chance Easter Seal quality rehabilitation programs give people with disabilities every day. So give to Easter Seals. **GIVE THE POWER TO BECOME.**

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Mini-internships taking hold across the state

Shari Hamilton, editor

Nothing motivates a man more than to see his boss putting in an honest day's work.
--Mark Twain

SINCE ITS INCEPTION, the SMS mini-internship program has garnered rave reviews from participants across the state. But what is it that makes this program linking physicians with public policymakers so successful?

To carry further the Samuel Clemens' quote appearing above, it can be motivating and enlightening for many of us to view for ourselves the level of dedication another person commits to his or her profession and ideals. It can inspire you to become more deeply involved with another person's causes and concerns; to proudly follow someone who has gained your respect.

The mini-internship program allows non-physicians to gain information on how our health care delivery system works, from the inside out. It also allows interns the opportunity to form personal relationships with physicians and see doctors as people who are working hard each day to do their best.

Says Jim Schleck, an intern in the recent Dane County mini-internship: "Dr Alan Schwartzstein was just terrific. He saw every patient in a timely fashion but still took time to do the little things, from educating a patient on smoking to handing out stickers to the small children. I really felt Dean's Urgent Care was well served by Dr Schwartzstein and his staff."

Schleck's reaction is not atypical. As anyone who has ever participated in a mini-internship can attest, the experience is more than just informative, it can change your entire perspective on medicine, the use of health care and the roles of physicians and patients.

Examples of those who have shared the internship experience are: TV reporters, news writers and editors, state lawmakers and their aides, hospital administrators and attorneys, large employers, and others who have a special interest in policies pertaining to health care access and delivery. The goal of the program is to build bridges between medicine and these policymakers so

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What a night! SMS Field Staff Representative Jim Schleck spent an evening in Urgent Care watching Dr Alan Schwartzstein handle numerous medical problems.

Continued from preceding page
fewer policies will be made based on financial "bottom lines" and more consideration will be given to the impacts policies may have on patients and physicians.

The SMS Commission on Public Information directs the mini-internship program. CPI member Robert E. Phillips, MD, of Marshfield, is a leading advocate for Wisconsin's mini-internship program.

Dr Phillips initiated one of the first mini-internships in the state in Wood County. The Wood County Medical Society is holding its fourth mini-internship program this month in Wisconsin Rapids and Marshfield. Dr Phillips and Joel M. Carlson, MD, of the Riverwood Clinic in Wisconsin Rapids, are chairing the planning committee. Other members include: Ade Dillon, MD; Michelle Bachhuber, MD, of Marshfield, and Richard W. Clausen, MD, and Marvin Vos, MD, of Wisconsin Rapids. Among the November interns in Wood County are: the editor of the Wisconsin Rapids Tribune, the Marshfield superintendent of schools, and a health aide to Gov. Tommy Thompson.

Although the internship program in Wood County is full grown, other counties are still in the fledgling stage. Milwaukee, Dane, La Crosse and the Eau Claire-Dunn-Pepin (EDP) County Medical Societies have all successfully completed their first mini-internship. Some counties opted for a one-day plan instead of the traditional two-day commitment to attract and enable busy interns to participate.

As often is the case in a profession where time is dear, it's been difficult for some counties just starting their programs to recruit physician volunteers. In EDP, however, 30 physicians paired off with 14 interns during various stages of the mini-internship program. VIP interns included Rep. Robin Kreibich, a Republican, and Sen. David Zien, a Republican. EDP plans a second mini-internship in two years.

Make no bones about it. Medicine is interesting work, especially to those who have examined an x-ray "up close and personal."

Jim Schleck, a participant in the Dane County mini-internship program, found a new niche, handing out stickers to young patients visiting Urgent Care.

For its second-mini-internship, Ashland County also attracted someone from Madison's Capitol Hill, Sen. Bob Jauch. The Democrat voiced strong appreciation for the informational program, and offered to put that support in writing.

When Jim Schleck, an SMS field representative, spent time peering over physician shoulders during the Dane County mini-internship, he came away with the following observation: "This program enlightened me to some of the hoops a doctor must jump through. For example, everyone has a different Worker's Comp form. Paperwork needs to be cut down."

"I learned a great deal," Schleck added, " It will make my job easier understanding what physicians go through on a day-to-day basis."❖

Kay Heggestad, MD, of Wildwood Family Clinic in Madison, converses with Sue Townscend during the Dane County mini-internship. Townscend, a nurse, is an assistant to Congressman Scott Klug.

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Meridian Resource Corporation, a subsidiary of Blue Cross and Blue Shield United of Wisconsin, currently has an excellent opportunity available for a Board Certified Pediatrician in active clinical practice who is interested in gaining insight and experience in the delivery of Health Care from a "different" perspective.

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Meridian Resource Corporation
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Milwaukee, WI 53203
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Wisconsin Medicaid managed care expansion: Background and implications

Kevin Wymore, SMS policy analyst

Background

In a major cost-containment initiative, the Wisconsin Medical Assistance Program (Medicaid) has announced plans for a statewide "managed care expansion." The Legislature recently enacted the plan as part of its 1995-1997 state budget. Mandatory recipient enrollment, which will affect about 83,000 recipients eligible for AFDC and Healthy Start, is scheduled to begin in July 1996. Capitated treatment of the new enrollees will begin in September 1996. For several months, Medicaid officials have convened meetings to solicit comment from interested parties about the plan. Key details of the proposal, such as the final HMO contract details, the actual HMO capitation rates and where various capitation rates will apply, have yet to be decided.

How will the program work?

The expansion is essentially a two-tiered plan:

HMOs: According to state budget documents and budget assumptions, HMOs will bid to provide comprehensive health services in areas of the state where Medicaid HMOs do not currently serve the target population. The budget assumes that 30 more counties will have mandatory enrollment, with patients being able to choose from at least two HMOs. Projected cost savings in the expansion areas will come from an 8% discount from current fee-for-service expenditures in the first 2 years of implementation. Then, capitation rates will be lowered further, to reflect the 9.5% rate applied to HMOs currently serving MA patients.

Primary Provider Program: In areas of the state where HMOs do not provide required coverage, Medicaid officials will attempt to establish a "Primary Provider Program." Targeted recipients will be required to choose a primary care provider and receive most non-emergency services through that assigned provider, or through referrals made by that provider. Participating physicians will receive a $3 per-patient-per-month case management fee, plus ordinary Medicaid fee-for-service payments. Key program goals are to give recipients a "medical home" and to reduce inappropriate emergency room visits.

According to the expansion plan, all areas of the state are expected to have either an HMO or a primary provider program managing the care of targeted MA recipients. However, HMOs' eventual decisions will determine which option -- HMO or Primary Provider Program--becomes available in your area. A key variable that will influence those decisions--how much HMOs will be paid--has yet to be finally decided. According to Medicaid staff, which option will be available in what counties won't be known until around June 1996.

Enrollment doesn't start until July 1996; what should I do now?

If you're interested in participating in the managed care expansion, you're not required to do anything right now. However, you may wish to learn as much as possible about the final details of the program once they emerge--through your SMS field representative, other SMS staff, or through Medicaid officials. An HMO representative may have already contacted you. **Note: The SMS advises against signing any agreement with any managed care company before carefully examining the details.**

Disclaimer

While care has been taken to ensure the accuracy of this document, Medicaid officials may change program details in this planning phase at any time. Please continue to read Medigram articles, consult with SMS field staff, or call the SMS for current information.❖

Details that you may wish to consider are: the proportion of your total practice revenue derived from Medicaid patients; the number of MA patients targeted for mandatory managed care enrollment in your service area; other demographic details of your practice; and, information on how capitation works. Before signing any contract, the SMS strongly advises physicians to seek expert legal and business advice. To get further information, call the SMS at 1 (800) 362-9080.

What does this mean for me? What are the pros and cons of HMOs?

The managed care expansion will only affect physicians who are MA-certified providers and who are still interested in serving the targeted AFDC and Healthy Start population after the program starts. If you don't take part, and you treat targeted recipients in an area served by HMOs, these patients will be reassigned to an HMO serving your area.

According to state Medicaid officials, possible benefits of participation are:

- No Medicaid billing requirements.
- Enrollees are locked into the

HMO for medical care for 6-month periods after the open enrollment periods, thus allowing for greater continuity of care.

- The possibility of increased reimbursement over what Medicaid ordinarily pays.
- Negotiations over reimbursement will be between you and the HMOs.
- Financial predictability stemming from a "per-patient-per-month" capitation payment.

According to the AMA, and the experience voiced by some physicians participating in the MA HMO program, disadvantages may be:

- Loss of autonomy and increased accountability for clinical decisions of their Medicaid patients. (Health plans will exert greater control over treatment decisions.)
- Reduced compensation for some physicians.
- Patient education about proper use of health services, (education is currently an HMO responsibility, but not always performed as well as physicians would prefer).
- Payment delays from HMOs. (Several physicians complain that HMOs needlessly delay payments to them.)

How will physicians be reimbursed under an MA HMO?

The contract between the HMO and the physician will determine how much physicians are paid, and how those payments are structured. This underscores the need to negotiate the contract with an HMO carefully, and to understand the supply and demand dynamics of your practice. For example, if a physician is the only practicing primary care physician in a certain county where an HMO wants to enroll patients, the physician will have better bargaining power than if the physician were one of many. An HMO may choose to pay a physician more than he or she would receive under current fee-for-service conditions set by the Medicaid maximum fee schedule, but this is not guaranteed.

How will HMOs make money if capitation rates are discounted that much?

According to the AMA report "Managed Care and the Market: A Summary of National Trends Affecting Physicians," the sources of cost savings for managed care plans are:

- *Reduced hospitalization.* The largest savings come from reducing inpatient hospital usage. (As a result, physicians are expected to account for a larger share of health expenditures in the future.)
- *Reduction of certain providers' payments, especially specialists'.* Cutting provider pay is another source of savings, though not nearly as important as hospital reductions.
- *Efficiencies in outpatient care.* As savings from the above areas plateau, more attention may be paid to outpatient savings--a relatively untapped area except in advanced group and staff model HMOs.
- *Preventive care.* Theoretically, savings from preventing illness could save money, but information on this technique is largely anecdotal, according to the AMA.

Information on profitability of the Medicaid portion of Wisconsin's HMOs is unavailable. However, Medicaid HMOs in Wisconsin have shown considerable interest in this market.

When will I know if my county or service area will switch to mandatory HMO enrollment for the target population?

Probably not until June 1, 1996, when the state's review of HMO certification will be complete and HMOs will have signed contracts, according to program officials. Again, you can check with field staff, the SMS headquarters or state managed care staff to give you current information on the transition.

When will the state actually switch targeted patients into capitation?

The initial transition is scheduled to begin on September 1, 1996. However, Medicaid officials plan to stagger the transition over a 6-month period. Some patients, therefore, may not be switched from fee-for-service until early 1997. The mechanics of that transition--which patients will be switched when--have yet to be decided, Medicaid staff say.

Where does the state already contract with Medicaid HMOs?

About 146,000 Medicaid recipients are enrolled in 11 HMOs in the following counties: Milwaukee, Dane, Eau Claire, Kenosha and Waukesha.

What is known about the effects of Medicaid managed care?

According to the 1995 Kaiser Commission report "Medicaid and Managed Care: Lessons from the Literature," the evidence suggests that:

- *Managed care shifts the type and site of care.* Most evaluation studies show a decline in the use of specialty services and in the use of emergency rooms. No consistent increase or decrease in the use of physician services or in inpatient care has been shown.
- *Data on cost savings is mixed.* Evidence on cost savings is almost equally divided between studies that show program savings and those that find program costs similar to or higher than fee-for-service models. (HMOs generally have been found to reduce costs, and Wisconsin Medicaid officials expect the HMO portion of the expansion to save over 9% compared to fee-for-service.)
- *Quality is comparable.* Medicaid managed care plans produce quality of care--measured by the presence of quality control standards, birth outcomes, and timeliness of care--that is similar to that found in fee-for-service arrangements.

Continued on next page

What will happen in rural areas, where HMOs have shown lesser penetration?

Medicaid HMOs have historically concentrated in urban areas, where more low-income people live. It remains unclear to what extent Medicaid HMOs will bid on the remaining 67 counties, many of which have few Medicaid recipients and low overall HMO penetration.

In Minnesota, where HMO market penetration has historically been high, the HMOs have elected not to serve rural counties to the same extent they have served the Twin Cities area.

Initially, Medicaid officials indicated that their budget assumptions called for 30 more counties to "have mandatory enrollment with a choice of HMOs." More recently, they have said that they intend to require patients to enroll in areas where only one HMO serves the area, as long as access can be guaranteed. "Access" has yet to be defined. The SMS has registered its concerns over this matter. Medicaid officials remain undecided about the issue's final resolution. In October, the SMS board approved policy stating that affected patients should be offered a choice of managed care plans.

How does the state propose to set capitation rates for the expansion counties?

MA officials have released plans for a regional rate-setting approach, instead of the county-by-county method now used. For counties targeted in the expansion, fee-for-service MA costs for calendar 1993 and 1994 will be averaged, and a weighted regional "per-member per month" figure developed. This will then be discounted by 8% (for serving an entire rate region-expansion counties). This discounted figure forms the basis for 1996 rates. (Some adjustments apply; that's the basic mechanism.) HMOs which choose not to serve an entire region will get a county-specific rate, but will get a reduced capitation rate for not serving the entire region. MA officials have released four maps containing different configurations, ranging from seven to 12 regions of contiguous counties. Copies of the regional maps and the underlying cost data are available from the SMS. A decision on what rate-setting plan will be used has yet to be reached.

What is the SMS doing about this initiative?

SMS staff have monitored the process surrounding the Medicaid managed care expansion closely. Physicians, SMS analysts, legal staff and others continue to follow the process, and field staff representatives will communicate these decisions as they become known. SMS field staff are also eager to hear your comments and suggestions.

In addition, SMS staff has introduced suggested changes to the proposed legal contract between the state and the HMOs. This key document will spell out certain details that may protect physician and patient interests. Among suggested changes are:

- Defining "medical necessity" in the context of reimbursing Medicaid HMO treatment;
- Using a "prudent lay person" standard for defining emergency medical services;
- Requiring HMOs to pay most clean reimbursement claims within 30 days, rather than 45;
- Narrowing the definition of "just cause" for a recipient to disenroll (in order to preserve patient continuity of care. (Currently, patients are allowed to switch providers every 6 months, unless there is just cause to disenroll); and,
- Requiring HMO payment for post-partum lengths of hospital stay of 48 hours for an uncomplicated vaginal delivery, and 96 hours for an uncomplicated cesarean delivery. Payment would be required only if physicians agree on the necessity of the stay.

Must I participate in this new program?

No. Participation in both the HMO expansion and the Primary Provider Program is voluntary. You may lose the AFDC and Healthy Start patients that you already serve if you choose not to participate.

How much money is this expansion expected to save?

About $7.5 million in fiscal year 1996-1997, according to program information. ❖

County society news

Brown. The Brown County Medical Society met in Green Bay at the Holiday Inn City Centre on September 14, 1995. The entertainment was country line dancing. The following physicians were approved for membership: Ahmet Dervisogullari, MD; Richard Jones, MD; Chris Larson, MD; Timothy Rearty,MD; Darren Heesacker, MD; David Kim, MD; David Brown, MD; Thomas Stoiber, MD; Todd Gallion, MD; and Theresa Oswald, MD.

Green. The Green County Medical Society approved membership for James J. Turek, MD; Philip C. Eckstrom, MD; Dean R. Schueller, MD; Daniel L. Reilley, MD; and Scott B. Lundgren, MD.

Kenosha. The following physicians were approved for membership in the Kenosha County Medical Society: Giuseppe Garretto, DO; Robert J. Swee, MD; Narinder Singh, MD; Charito dela Torre, MD; Timothy J. Zellko, DO; Patricio Luis B. Ilanda, MD; and Julie A. Swain, MD.

La Crosse. The following physicians have been approved for membership in the La Crosse County Medical Society: Scott A. Ensminger, MD; Scott A. Escher, MD; Timothy S. Hanson, MD; Benjamin H. Johnson, MD; Mark S. Perpich, MD; and John M. Teske, Jr, MD.

Marathon. The Marathon County Medical Society approved membership for James R. Messerly, MD.

Milwaukee. The following physicians were approved for membership in the Medical Society of Milwaukee County: Linda J. Barrows, MD; Bart L. Cox, MD; George A. Fueredi, MD; Joseph E. Geenen, MD; Timothy S. Hart, MD; Emil Douglas Hurst, MD; Yakov Ivanov, MD; Michael W. Kilby, MD; Kathryn M, Kiyono, MD; Kathy J. Kowalke, MD; Lorelle L. Kramer, MD; Kathryn K. Leonhardt, MD; Young Ja Moon, MD; Mark D. Moglowsky, MD; Gary F. Neitzel, MD; Edward J. Rosenthal, MD; Jay F. Schamberg, MD; James A. Siy, MD; Mauricio Tovar, MD; Benedicto P. Uy, MD; Vani Dandolu, MD; Devang V. Gandhi, MD; Maureen P. Lavin, MD; Muhammad Fayaz Malik, MD; Jure Marijic, MD; Marcus E. Moseley, MD; Mark W. Niedfeldt, MD; Timothy S. O'Brien, MD; and Michael J. Volk, MD.

Outagamie. The Outagamie County Medical Society approved membership for John I. Halloran, MD.

Ozaukee. Gerard W. Dynkowski, MD; and Gary R. Figge, MD; have been approved for membership in the Ozaukee County Medical Society.

Rock. The Rock County Medical Society approved membership for Kevin Bluemel, MD; Geoff Bouc, MD; Ivan Chavez, MD; Michael Coogan, MD; Nancy Deming, MD; Mark Golden, MD; Robert Gordon, MD; David Hugelmeyer, MD; Franz

Continued on next page

AMA awards

The Wisconsin physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates members of the SMS.

August 1995

* Bemmann, Kathryn M. Chizek
* Bradley, Walter J.
  Braun, Andrew J.
* Charipar, Ron M.
* Coleman, Edward J.
* Holzgrafe, Robert E.
* Keenan, Owen B.
* Kroll, Mark R.
* Kuehner, Marvin E.
* Lagus, Arne T.
* Malinowski, Rodney W.
* Mattox, Suzanne P.
* Rieder, Michael J.
* Salvi, Frank J.
* Siepmann, James P.
* Stanley, Robert J.
* Ulmer, Richard H.
* Warpinski, Luke T.
* Welsh, Brady T.
* Wenman, Michael S.
  White, John D.

September 1995

* Bernstein, Harvey H.
  Bomzer, Charles A.
  Cooper, Ronald J.
* Crummy, Andrew B.
* DeKraay, Warren H.
* Ejercito, Victor S.
* Errico, Charles A.
* Faber, John W.
* Grossman, Ronald E.
* Hantsch, Christina E.
  Hussa, John F.
* Johnson, Sidney E.
* Kidder, Thomas M.
* Klessig, Heidi T.
* Nellen, James R.
* Park, Roger W.
* Reuter, Catherine F.
* Riese, David C.
* Smalley, John J.
* Thomalla, James V. ❖

Continued from preceding page
Keilhauer, MD; James Kirshbaum, MD; Paul Koberna, MD; Gail Moreschi, MD; Richard Radak, MD; Margaret Wilcots, MD; Angus Wilfong, MD; David Wolff, MD; Frank Agatucci, MD; Teresa Brown, MD; Robert Cornish, MD; Tina Kosnar, MD; Kerilynn Loftus, MD; Ronald Horkheimer, MD; Paul Sauer, MD; Chris Stroud, MD; and Todd Swenson, MD.

Taylor. The Taylor County Medical Society approved membership for Sheila M. Farrell, Md; Keith Cole, MD; Catherine Reuter, MD; and Mark Rueter, MD.

Walworth. Larry LaCrosse, MD; and David D. McPherson, MD; have been approved for membership in the Walworth County Medical Society.

Waukesha. The Waukesha County Medical Society approved membership for the following physicians: Mahmood H. Al-Wathiqui, MD; Michael Biehl, MD; Robert J. Brodish, MD; Robert H. Fisher, MD; Kalpana M. Kumar, MD; Elizabeth S. Miller, MD; Krishna R. Prasad, MD; Srutha K. Rajkumar, MD; David A. Stone, MD; and Marie K. Thorsen, MD.

Winnebago. The Winnebago County Medical Society met on September 7, 1995, at Robbins Restaurant in Oshkosh. SMS field representative, Jim Schleck updated members on Medicare. Dr Tim Flaherty outlined several national issues concerning Medicare proposals and Washington outcomes.

Wood. The Wood County Medical Society met at the Antlers Supper Club and Sandbar in Mosinee on August 24, 1995. Dr Robert Phillips presented a brief overview of the upcoming mini-internship program. New members approved are: Peter J. Barbian, MD; Wayne R. Christie, MD; G. Patrick Connor, MD; and Douglas P. Galuk, MD. ❖

Alliance prompts Thompson to sign proclamation on SAVE day

THE SMS ALLIANCE was successful in having Gov. Tommy Thompson declare Oct 11 as Stop America's Violence Everywhere (SAVE) day. (See proclamation, next page.)

Alliance members across the state have worked to increase awareness of violence, especially domestic abuse, during this month which was nationally recognized as Domestic Violence Awareness Month.

The slogan for the campaign is "Break the Silence...Begin the Healing." In addition to spreading information about the use of trigger locks as a deterrent against youth injury, Alliance members have sponsored billboards and distributed posters to stores, restaurants and businesses.

A bill sponsored by SMS Board Director and state Rep. Frank Urban, MD, is now being considered in the state Legislature. The bill would require all purchasers of new firearms to buy trigger locks. The SMS is also supporting another bill that would prevent people who have domestic violence restraining orders against them from purchasing guns.❖

SMS commission recommends use of carbon monoxide detectors

AS WINTER IS APPROACHING and furnaces are being turned on, the problem of carbon monoxide poisoning increases. Joe Wade from Wisconsin Natural Gas recently provided the SMS Commission on Environmental and Occupational Health information on signs and symptoms of CO poisoning that physicians should be aware of during winter months.

Symptoms include: headaches, dizziness, sleepiness, nausea and vomiting, fluttering or throbbing in the chest and irregular breathing. Physicians may find that a patient's symptoms disappear upon leaving the home. Wisconsin Natural Gas and Wisconsin Electric are currently selling carbon monoxide detectors which are reliable and relatively inexpensive. For more information call Wisconsin Natural Gas at 1-800-842-0926 or Lynn Sherman at the SMS, 1-800-362-9080 or (608) 257-6781. ❖

The State of Wisconsin

OFFICE OF THE GOVERNOR

A PROCLAMATION

WHEREAS, violence is among the leading causes of death in America, and has replaced disease as the number one killer of children; and

WHEREAS, domestic violence has devastating effects on a woman's physical and emotional well-being, and her ability to care for her children; and

WHEREAS, violence comes in many forms: sexual violence; gang and peer-related violence committed by youth of all ages; family violence; street violence; and violence in the media; and

WHEREAS, billions of dollars per year are attributable to preventable violence-related deaths and injuries and add a tremendous burden to American's health care system; and

WHEREAS, the first step toward unraveling the many layers of our nation's vilence problems can begin with awareness; and

WHEREAS, awareness and prevention are the heart of the SAVE Program and of its cornerstone event, SAVE Today, during which physicians' spouses across the country will join efforts to Stop America's Villence Everywhere; and

WHEREAS, members of the Medical Alliance of the State of Wisconsin will lead the effort to urge local citizens to search for ways we can all help SAVE Today for Tomorrow;

NOW, THEREFORE, I, TOMMY G. THOMPSON, Governor of the State of Wisconsin do hereby proclaim October 11, 1995

SAVE TODAY FOR TOMORROW DAY

in the State of Wisconsin in support of the need to educate people and help victims of violence.

IN TESTIMONY WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Wisconsin to be affixed. Done at the Capitol in the City of Madison this fourth day of October in the year one thousand nine hundred ninety-five.

By the Governor

TOMMY G. THOMPSON

Obituaries

Altshuler, Charles H., MD of Fox Point, died July 29, 1995. His research, tracing how memory loss in the 30s, 40s and 50s could be linked to five generations of his family helped prove a genetic link to the disease. He became head of St Joseph's pathology department in 1953. He retired in the mid-1980s. He is survived by his wife, Selma and daughters, Dale Altshuler, of Fox Point, and Lynn Altshuler, of San Francisco.

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.❖

Belzer, Folkert, MD, died Aug 6, 1995, in Madison. He specialized in kidney transplants at the UW-Madison Medical School, the nation's third largest transplant center. In 1960 he developed a perfusion preservation machine that allowed organs to be kept viable for several days. In 1971 he was able to transport a kidney from San Francisco to Holland, the first transcontinental sharing of an organ. It was successfully transplanted into a patient after being preserved for 37 hours. His greatest contribution was in 1987 when he and biochemist Doctor James Southard developed "UW solution" a fluid that can usually keep donated organs viable from 18 to 30 hours or longer. The extra time allows surgeons to better match organs to the recipients, reducing rejection rates. The solution also reduces the cost of transplants which revolutionized liver transplantation. In April he received one of the highest honors for a surgeon, the Medallion for Scientific Achievement, from the American Surgical Association. The award was only the 12th in the Association's 117 year history. Dr Belzer was born in Indonesia in 1930. He moved to the United States after World War II and earned his chemistry degree from Colby College, Me, in 1953. He received a master's degree in biology in 1954 and earned his medical degree in 1958 from Boston University. He came to the UW Madison Medical School in 1974. He is survived by his wife, Marion, and four grown children.

Biller, James H., MD, died Aug 8, 1995, in Milwaukee. He earned his undergraduate and medical degrees at Marquette University, served in the US Army Medical Corps during World War II, and practiced medicine as a family practitioner for over 50 years. He is preceded in death by his wife, Ida, and is survived by his son, Dr Harold Biller, a pathologist, two grandchildren and five great grandchildren.

High, Howard C., MD, died July 9, 1995, in Milwaukee. He set up an ear, nose and throat practice in Milwaukee in 1947. He taught his specialty at the former Marquette University Medical School. He is survived by his wife, Anne, also a physician, and three children, Edith Sanchez, of La Jolla, Calif, Alice Sperling, of Corvallis, Ore, Charles High, of Shorewood and six grandchildren.

Kendell, William George, MD, died Aug 19, 1995. He was born on Oct 20, 1922. He attended the University of Michigan and University of Michigan Medical School. He served his externship and internship at Pennsylvania Hospital, Philadelphia, residency in Burlington County Hospital, Mount Holly, New Jersey, and Henry Ford Hospital in Detroit. He is survived by his wife, Phyllis; a son, William Scott, of Benham, Texas; a daughter, Diane Pakula, of Telegraph Creek, B.C.; and six grandchildren.

McGinnis, Howard J., MD, died Aug 26, 1995, in Waupaca. He was born Nov 29, 1908. He is a graduate of Marquette University of School of Medicine. He earned his internship at St Mary's Hospital Milwaukee. He was a member of the Fifty Year Club of the State Medical Society of Wisconsin, the American Medical Association, Michigan State Medical Society, American Academy of Family Practice, Association of Military Surgeons of the US, Dodge County Medical Society, Racine County Medical Society, Branch County Medical Society and Phi Beta Pi medical fraternity. He was preceded in death by his wife, Mary, and is survived by two daughters, Margaret Listug of Stoughton and Dr Kathleen J. McGinnis of Stevens Point, and two grandchildren.

Peterson, Freddie Nadine, MD, died July 21, 1995 in Oconomowoc. She was born June 26, 1911, in Varna, Ill. She practiced medicine from 1971 to 1972, at the Harland Clinic.

From 1972 to 1990, she operated a private practice of pediatric and plastic surgery in Oconomowoc. She was medical director at the Oconomowoc Development Training Center and was on the staff of Memorial Hospital at Oconomowoc from 1971 to 1990. She is survived by one daughter, Valerie Anne Peterson, of Racine, and one sister, Jacquelyn P. Fuller, of Menlo Park, Calif.❖

Physician briefs

*Denotes SMS member

Roderick S. Brodhead, MD*, has joined the staff of the Mercy Walworth Urgent Care Center. He is a board-certified emergency medicine specialist. Dr Brodhead, a fellow of the American College of Emergency Physicians, graduated from the University of Wisconsin Medical School and completed a general surgery internship at Gunderson Clinic and Lutheran Hospital in La Crosse.

Shirley J. Dawson, PhD, MD*, has joined the Dean Foundation as a research physician in psychiatry. She completed a Geriatric Research Education and Clinical Center fellowship at the Middleton Veteran's Hospital in Madison. Dr Dawson will initially be working on a depression in primary care study and eventually hopes to do research in the area of Alzheimer's disease. She received her PhD and medical degree from the University of Minnesota, Minneapolis. She completed her residency at the University of Wisconsin Hospital and Clinics in Madison.

Terence S. Edgar, MD*, has joined the staff at the Mercy Clinic West Urgent Care Center in Evansville. He earned his medical degree from the University of Pretoria in South Africa, where he specialized in pediatrics. He has a diploma in aviation medicine from the South African Institute of Aviation Medicine and a diploma in tropical medicine and hygiene from the University of Witwatersrand. He served as a flight surgeon and medical officer in South Africa and is currently a resident and fellow in child neurology at the UW Medical School in Madison.

John Erbes, MD*, has recently published a book titled, "Hell-on-Wheels Surgeon." The book describes his introduction to surgery while serving as an officer in the Army Medical Corps in "some of the most momentous battles of World War II in North Africa, Sicily, France, Belgium, Holland, and Germany."

John J. Eversman, MD*, of Elm Grove, has been appointed chief executive officer of the Board of Medical College of Wisconsin Physicians and Clinics. He is senior associate dean for clinical affairs and associate professor of clinical medicine at the Medical College. He will serve as chair of the executive committee, as well as an ex-officio, non-voting member of the board. Dr Eversman joined the faculty in 1993 after 22 years in management at the Cleveland Clinic Foundation, the last ten as chief operating officer and vice chairman of the board of governors. He earned his medical degree in 1960 from the University of Iowa College of Medicine and interned at the Milwaukee County Medical Complex. He completed a residency in internal medicine and fellowship in endocrinology at the Cleveland Clinic Foundation and received an MBA from Case Western Reserve University in 1983.

Badri N. Ganju, MD*, joined the staff of the Sheboygan Clinic. Dr Ganju received his medical degree at the Government Medical College in Nagpur, India. He completed a rotating internship at the Medical College Hospital in Nagpur and a surgical internship at the Illinois Masonic Medical Center in Chicago. Dr Ganju completed his residency in general surgery at Wayne State University in Detroit, Michigan, and at the University of Illinois-MGH Program.

Betty J. Hagle, DO, has joined the staff of the Red Cliff Community Health Center. She received her degree from the Chicago College of Osteopathic Medicine in 1961. She previously practiced medicine at a rural health center in Leona.

Cyril M. Hetsko, MD*, infectious disease specialist at Dean Medical Center, has been renominated to serve a three-year term on the American Society of Internal Medicine's Board of Trustees.

Ronald Horkheimer, MD*, an emergency medicine specialist, was hired by Mercy Health System to staff the Mercy Clinic West Urgent Care Center. He graduated from the Medical College of Wisconsin in Milwaukee, and completed a fellowship at Sumve Hospital in Mwanza, Tanzania, where he gained experience with tropical and parasitic diseases. He completed a rotating internship at Mercy Hospital in San Diego, Calif, and a residency in obstetrics and gynecology at St Joseph's Hospital

Continued on next page

Continued from preceding page
in Milwaukee. He also was a flight surgeon in the Navy and has served as an emergency medicine physician.

Arif Jaka, MD, has joined the staff of the Lakeland Medical Center, Elkhorn. He is a family practice physician and received his medical degree from Sind Medical College, Karachi, Pakistan. He completed his internship and residency at Hennepin County Medical Center, Minneapolis, Minn.

Jack Klieger, MD*, was named one of the "10 Most Admired Senior Citizens of Wisconsin" at the Wisconsin State Fair in August. The award recognizes the unsung contributions of the state's senior citizens to their families, friends and communities. Dr Klieger began his practice in downtown Milwaukee in 1944, but made a personal commitment to care for indigent patients about 20 years ago. His volunteer work has expanded to include obstetrical care for patients at the Milwaukee Indian Health Care Center.

Tina Kosnar, MD*, has joined the staff of Mercy Options-Comprehensive Mental Health and Addiction Treatment Services, specializing in child and adolescent psychiatry. Dr Kosnar is a graduate of Creighton University School of Medicine in Omaha, Nebraska, where she completed an internship and residency in psychiatry. Currently she is an assistant professor at the University of Hawaii School of Medicine.

Gerald H. Klomberg, MD*, has been named medical director at the Clearview Long Term Care and Rehabilitation Center in Juneau. He has more than 30 years experience in private practice. Dr Klomberg received his medical degree from Marquette University School of Medicine and completed an internship and three years of internal medicine resident training at Milwaukee County Hospital.

Sharry Kreitlow, MD, has joined the medical staff of the Marshfield Clinic-Chippewa Center, as an obstetrician/gynecologist. She earned her medical degree from the Medical College of Wisconsin in Milwaukee, and served her residency in ob/gyn at the University of Minnesota Hospitals and Clinics.

David Lippie, MD*, a general surgeon, recently became a member of the Monroe Clinic staff. He is skilled in general, vascular and laparoscopic surgery. Dr Lippie received his medical degree from Indiana University School of Medicine, and completed his internship in general surgery at St Joseph Mercy Hospital and his general surgery residency at Butterworth Hospital, Grand Rapids, Mich. He completed his fellowship in surgical critical care at Butterworth Hospital.

Keith Martin, MD, Ob/Gyn, joined the staff of Hartford Memorial Hospital in September. Dr Martin comes from Breese, Ill, where he held private practice since 1992. He earned his medical degree from Chicago Medical School and completed his residency and internship at Oakwood Hospital in Dearborn, Mich.

Robert H. McLaren, MD*, a urologist with LaSalle Clinic, has been appointed to the medical staff at Ripon Medical Center. He received his medical degree from the University of Michigan School of Medicine, and completed an internship and residency in urology at the Mayo Clinic in Rochester, Minn.

Alfonso Morales, MD, joined the Baldwin Hospital and Ramsey Clinic-Baldwin in September. He recently finished his internship/residency in family practice at Roanoke, Virginia. He received his medical degree from LaSalle University Medical School in Mexico City, Mexico.

Michael Netzel, MD*, has joined the Monroe Clinic, and will head the pulmonology and allergy departments. He received his medical degree at Creighton University School of Medicine. He completed his internship and residency in internal medicine at Creighton University Affiliated Hospitals in Omaha, Neb. His fellowships were in the areas of allergy, immunology and pulmonary disease.

Gordon Olinger, MD, professor and chairman of cardiothoracic surgery at the Medical College of Wisconsin, has been elected vice-chairman of the Board of Medical College of Wisconsin Physicians and Clinics. Dr Olinger joined the medical college in 1976 and is a nationally known thoracic surgeon and a recently appointed director of the American Board of Thoracic Surgery. A 1968 medical graduate of the University of Rochester, Dr Olinger served an internship in general surgery, and completed residencies in general and thoracic surgery at the University of California-Los Angeles.

Dilip Purohit, MD, joined the Marshfield Clinic-Indianhead Center. He earned his medical degree from the University of Rajasthan in Jaiput, India. He served his residency in internal medicine at SUNY Health Science Center in Syracuse, New York.

Christopher J.N. Rall, MD, has joined the medical staff of the Marshfield Clinic. He received his medical degree from the Medical College of Virginia, Virginia Commonwealth University in Richmond, Virginia. He served his residency in internal medicine at Massachusetts General Hospital in Boston, Mass, and completed a fellowship in gastroenterology at Massachusetts General Hospital.

Daniel Reilly, MD*, a psychiatrist, was hired by the Monroe Clinic. He specializes in mental health care. He received his medical degree from the University of Osteopathic Medicine and Health Sciences in Des Moines, Iowa. He completed a residency in psychiatry from Menninger School of Psychiatry in Topeka, Kansas.

Herbert F. Sandmire, MD*, clinical professor and Green Bay obstetrician, recently became the first recipient of the special recognition award for an outstanding Wisconsin obstetrician and gynecologist. The award was presented at the annual meeting of the Wisconsin Section of the American College of Obstetrician and Gynecologists. More than 600 physicians have received education and training in Green Bay through programs developed and directed by Dr Sandmire. His literature contributions include more than 30 published articles. Dr Sandmire has served on various Wisconsin boards and committees, and has been the recipient of numerous research and teaching awards during his career.

Ralph M. Schapira, MD, assistant professor of medicine at the Medical College of Wisconsin, has been appointed the physician consultant to the Department of Veteran's Affairs National Center for Cost Containment, which is located at the Zablocki VA Medical Center in Milwaukee. In addition, Dr Schapira will continue as the physician director of the medical intensive care unit at the VA Medical Center-Milwaukee, and with his regular pulmonary and critical care duties at the VA and Froedtert Memorial Lutheran and John L. Doyne hospitals.

James D. Simonds, MD*, has joined the family practice department of All Saints Healthcare System in Union Grove. He graduated from the UW-Madison Medical School and completed his residency at Wheeling Hospital, Wheeling, West Virginia.

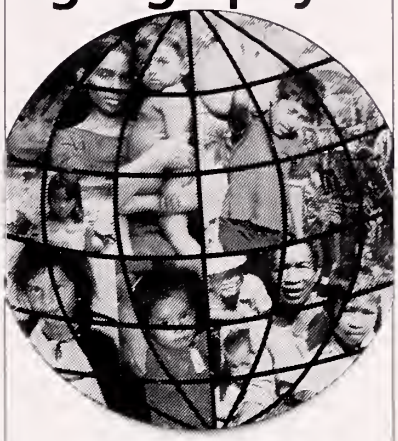
Lisa M. Simonds, MD*, will join the family practice department of the All Saints Healthcare System in Union Grove. She graduated from the UW-Madison Medical School and completed her residency in family practice at Wheeling Hospital, Wheeling, West Virginia.

Raj V. Singh, MD*, joined the medical staff at Marshfield Clinic-Stanley Center. He served his residency in internal medicine at St Joseph's Hospital and Medical Center in Paterson, New Jersey. He earned his medical degree from JN Medical College in Aligarh, India.

Melish A. Thompson, MD*, a Milwaukee area cardiologist, has joined Milwaukee Medical Clinic's Cardiac Center. He received his medical degree from the University of California in San Diego, and completed his internship and residency in internal medicine and a fellowship in cardiology at the University of Iowa in Iowa City. He is the immediate past director of the cardiovascular laboratory and division chairman of the department of cardiology at Columbia Hospital.

J. Frank Wilson, MD*, professor and chairman of radiation oncology and interim director of the Cancer Center at the Medical College of Wisconsin, was recently elected chairman of the Board of Medical College of Wisconsin Physicians and Clinics. Dr Wilson joined the Medical College faculty in 1974. He is an internationally known researcher in radiation oncology and an authority on breast cancer. He earned his medical degree from the University of Missouri School of Medicine in 1965 and completed an internship through the US Public Health Service in New Orleans and a residency in radiation oncology at the Penrose Cancer Hospital in Colorado Springs, Colo.❖

Won't you please help these innocent victims of geography?



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MADISON, WISCONSIN - URGENT CARE. Dean Medical Center, a 350+ physician multispecialty group, is seeking a full time physician to assist in staffing our two urgent care centers. Qualified applicants should BE/BC in Family Practice, Emergency Medicine or Internal Medicine with experience in Pediatrics. Dean Medical Center operates two Urgent Care Centers 365 days per year, from 7:00 a.m. - 10:00 p.m. All physicians employed at the urgent care centers are paid on an hourly basis, and full time physicians are eligible to buy into the corporation after two years of employment. Excellent compensation and benefits. Contact Scott Lindblom, Dean Medical Center, 1808 W. Beltline Highway, Madison, Wisconsin, 53715-0328, 1-800-279-9966 or (608)250-1550 or FAX (608)250-1441. 11-12/95;1-3/96

EMERGENCY MEDICINE - WISCONSIN. Position available to join young, well established, residency trained/board certified EM group located in southern Wisconsin. Recently renovated, state-of-the-art ED and hospital facilities with strong medical staff support, ED volume of 30,000 plus with MD/PA double coverage. Opportunities for academic affiliation available if desired. Benefit and comprehensive package in excess of $150,000 for first year. Strong, stable local economy with low cost of living. Easy drive to Chicago, Madison and Milwaukee. For more information send CV to: Jacquelyn Degenhardt, Physician Recruitment, BELOIT MEMORIAL HOSPITAL, 1969 W. Hart Road, Beloit, WI 53511, 800-637-2641, ext. 5757. e-mail: BMH-jfd@bossnt.com. 11/95-1/96

MADISON, WISCONSIN. Dean Medical Center, a 350+ physician, private, multi-specialty group, is actively recruiting a BE/BC internist to join our Dean Clinic (our main building) on Fish Hatchery Road in Madison. The Fish Hatchery Road, Middleton, and our West Madison Clinic share a call schedule which is approximately a one in ten call schedule. A two year guaranteed salary plus incentive and benefits is being offered for this position. For more information contact Scott M. Lindblom, Medical Staff Recruiter, Dean Medical Center, 1808 West Beltline Highway, Madison, Wisconsin, 53713, work (608)250-1550, home (608)833-7985 or fax (608)250-1441. 11-12/95,1/96

JANESVILLE, WISCONSIN. Dean Medical Center, a 350 physician multispecialty group, is actively recruiting additional BE/BC family physicians to practice at the Riverview Clinic locations in Janesville, Milton and Delavan, Wisconsin. Janesville, population 55,000, is a safe, beautiful, family oriented community with excellent schools and abundant recreational activities. Excellent compensation and benefits are provided

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with employment leading to shareholder status. Send CV to Stan Gruhn, MD, Riverview Clinic, P.O. Box 551, Janesville, WI 53547, or call (608)755-3500. 11-12/95;1-10/96

PLATTEVILLE, WISCONSIN. Dean Medical Center, a 350+ physician private multi-specialty group is actively recruiting a BE/BC internist to join their affiliated Doctors Park Clinic in Platteville, Wisconsin (population 10,000). The current staff consists of four family practice physicians, one general surgeon and three physician assistants. Each physician works 4-1/2 days per week, sees approximately 25 patients per day. A minimum $115,000 guaranteed salary plus incentive is provided. There is also a loan forgiveness program being offered for eligible physicians. For more information, contact Scott M. Lindblom, Medical Staff Recruiter, Dean Medical Center, 1808 West Beltline Highway, Madison, Wisconsin, 53713, work (608)250-1550, home (608)833-7985 or fax (608)250-1441. 11-12/95;1/96

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EMERGENCY MEDICINE: WISCONSIN. Be a partner in your own democratic partnership in a family oriented community close to Milwaukee. Low volume ED. Medical Director and Full-time and Part-time positions available. Call 414-332-6228 or send CV to the Emergency Resources Group, 509 West Montclaire Avenue, Milwaukee, Wisconsin, 53217. 9/95-2/96

PORTAGE, WISCONSIN - Family Practice opportunity in rural setting near Madison, Wisconsin. Affiliated with the University of Wisconsin Medical Center. Call shared 1:5. Progressive hospital. Three year contract with incentives and great CME benefits. Four weeks vacation. Safe, family oriented environment. Wonderful recreational area. Contact Provider Relations Coordinator at University Community Clinics, 1-800-844-5357, ext. 257. 9-12/95

BEAVER DAM, WISCONSIN - Rural practice opportunity near Madison, Wisconsin. General Internal Medicine practice with two other internists. Call shared 1:5. Affiliated with the University of Wisconsin Medical Center. Three year contract with incentives, and great CME benefits. Four weeks vacation. Safe, family oriented environment. Beautiful four seasonal recreational area. Contact Provider Relations Coordinator at University Community Clinics, 1-800-844-5357, ext. 257. 9-12/95

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11-12/95

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20th Annual Winter Pediatric Seminar
Indianhead Mountain Resort
Wakefield, MI
Contact: Marshfield Clinic, Office of Medical Education, 1000 North Oak Ave, Marshfield, WI 54449, 1-800-541-2895.
11/95-1/96

February 29-March 1, 1996
Practical Strategies in the Evaluation and Management of the Geriatric Patient
Indianhead Mountain Resort
Wakefield, MI
Contact: Marshfield Clinic, Office of Medical Education, 1000 North Oak Ave, Marshfield, WI 54449, 1-800-541-2895.
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Wausau Medical Center 606

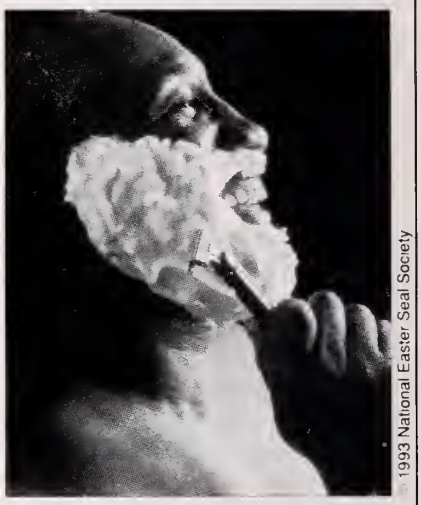
THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, clinics, specialty societies, and medical schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 70 cents per word, with a minimum charge of $30.00 per listing. *All listings must be prepaid.*

BOXED LISTINGS: $40.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 1st of the month preceding the month of publication: eg, copy for the August issue is due by July 1. Address communications to: *Wisconsin Medical Journal*, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free 1-800-362-9080.

OTHER MEETINGS in the United States are published in the first issue of each month of the *Journal of the American Medical Association.*

To some people their daily routine is a daily triumph.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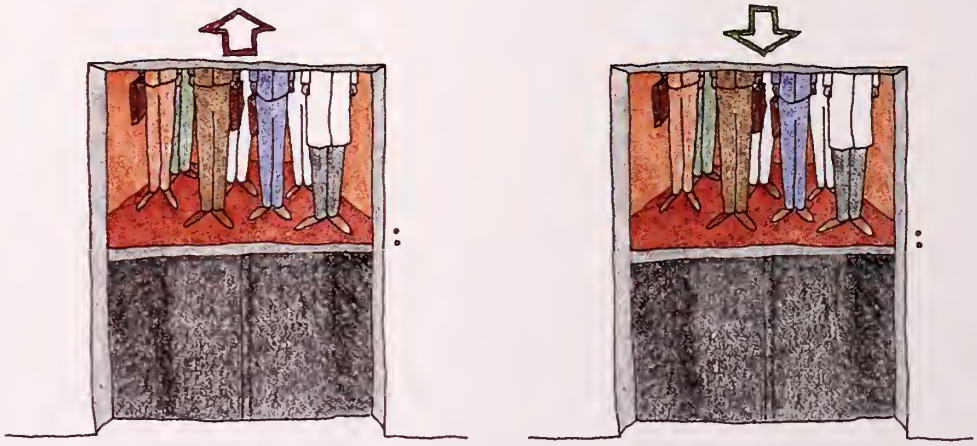

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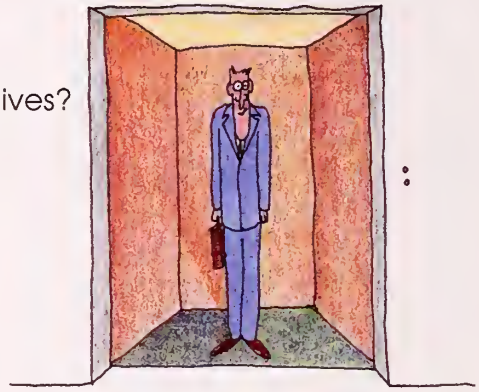

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Created by the Territorial Legislature in 1841 and now representing nearly 8,500 member physicians, the Society's purpose is to "advance the science and art of medicine and the health of the people of Wisconsin; ensure that physicians are equipped to deal effectively with the economic and political aspects of practice; and serve as the patient and physician advocate to government and other relevant publics." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal*.

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Our cover: A celebration of equality: Across the nation, medical students of both sexes are pursuing their dreams. Males outnumber females at the Medical College of Wisconsin but this year for the first time women medical students outnumber men at the University of Wisconsin Medical School.
See related stories on pages 703-709.

Cartoon illustration by Andrew Toos

Uncertain Times: Preventing Illness, Promoting Wellness

1996 International Conference on Physician Health

Sponsored by the American Medical Association, the Canadian Medical Association, the Federation of State Medical Boards, the Federation of Medical Licensing Authorities of Canada, the Federation of State Physician Health Programs

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In cooperation with the American Society of Addiction Medicine and the Society for Professional Well-Being

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A New Focus...
In these times of uncertain economic forces and rapidly advancing scientific knowledge, the stresses of keeping one's practice current and financially viable exact their toll on physicians. Physician health now includes a broad, pro-active, preventive approach of reducing all types of physician health problems and offering assistance before there is actual impairment.

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Pre-Conference Institutes will include:

Update on Chemical Dependency: Edward Senay, MD, - *Cocaine;* Robert Swift, MD, PhD - *Current Pharmacologic Management Strategies;* Norman Miller, MD, - *Assessment and Management of Dual Diagnosis*

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Women's Health, 1996: Erica Frank, MD, MPH - *Research Needs and Plans;* Carol Scott, MD, MPH - *Violence as a Healthcare Issue;* Michael F. Myers, MD - *Relationships and Other Mental Health Issues*

Recreation
When not discussing physician health issues, promote your own personal health. You will find an 18-hole championship golf course, several swimming pools, and tennis courts – two lit for night play. Enjoy jogging around the golf course, bicycling in the balmy southwestern breeze, horseback riding on the edge of town or working out at the nearby fitness center.

For additional information on how to register for this important Conference
Write, call or fax: International Conference on Physician Health, American Medical Association, 515 N. State Street, Chicago, IL, 60610, 800 621-8335, fax: 312 464-5826.

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President's page
Holiday reflections...

O God, give us serenity to accept what cannot be changed,
and courage to change what should be changed, and
wisdom to distinguish the one from the other.
...Dr. Reinhold Niebuhr

THE WEEKS BETWEEN Thanksgiving and the New Year will never quite be the same for me since my experiences of this last year. I will continue to enjoy the holiday spirit, consume my fill of caloric goodies, party with friends and coworkers, and exchange gifts with family. But no longer will my mother be here to celebrate. And age has changed my father, who has isolated himself in his senile brain. Rarely now do I recognize the man who nurtured me, who encouraged me to become a physician. Instead, I see a familiar face with foreign eyes and hear from his lips angry words. I have difficulty accepting these changes in my life. Now, too, almost a year has passed since my daughter was married. This I accept easily for grandmotherhood cannot be far. How 12 months have transformed my life.

I realize more intensely this year the value and importance of family. I appreciate more their unqualified acceptance of all aspects of my person, their willingness to stand by me in good times and bad, and their patience in listening to me expound on my dreams and disappointments. My extended, loving family, which includes my friends, provided me the support to endure these difficult times; to ultimately emerge I believe stronger, wiser, and more tolerant. Without the love of family I might not look forward with joy to this holiday season.

The family of medicine has also had a difficult year. This year has been one of rapid change, challenges, and confrontation for many of us as physicians. We are increasingly addressed as providers (not doctors), spoken about as if we are a commodity by some administrators and governmental officials, are more frequently challenged when we try to do the right things for our patients, and find some fellow physicians our adversaries on issues. Our family of medicine has been under increasing stress, not the least of which is the expansion of managed care.

During these difficult times, I hope that all of us will rally about each other, as my extended family rallied about me. But the coming together of physicians is increasingly more difficult. We, like our American society, are becoming more diverse, and it is too easy to emphasize our differences and

Marcia J. S. Richards, MD

spend time in disagreement, rather than emphasize our common values and work together to solve mutual concerns. Diversity, like the silver lining in a cloud, can have benefits for us as physicians. It may help lead to new approaches to medical problems and the practice of medicine, or it can weaken us through divi-

Continued on next page

Continued from preceding page
sion. The choice is ours to make as a profession.

I believe if we remember at times of debate and disagreement among us as physicians, that we are all patient advocates first, we will flourish rather than flounder. The family of medicine can be our support in these difficult times, if we allow and encourage it to be, just like my family was during this past year.

Let me take presidential privilege in this holiday column, and wish to both our families, genetic and professional, a joyous holiday season and a productive and creative new year.

EVP report: The view from here
Violence strikes home with employee shooting

"The truth of it is, the first rudiments of education are given by parents."
--Sir Richard Steele

IT WAS A CHILLY Monday morning on Nov. 6 when moments after I walked into the office I learned one of our SMS staff members had been shot over the weekend. It's difficult to explain the shock I went through when I heard the news. All that day, questions about the senselessness of this tragedy kept popping up.

Jackie Millar was shot in the home of a friend in Reedsburg, allegedly by two boys, ages 15 and 16. News reports say the children were tired of walking so they went into the garage of the rural home of Jackie's friend and decided to steal her car. After Jackie discovered the intruders in the garage, the teens allegedly took Jackie back into the home. Reportedly, one of the teens later shot Jackie in the back of her head with a .22-caliber pistol. News reports state both teens were carrying guns.

Like most staff members here at the SMS, this tragedy left me wondering how this could have been avoided. What could the parents of these children have said or done to prevent this crime? And finally, where did those teenagers get those guns?

It makes me question the safety of my own family and it raises my awareness of the violence in society. As a parent, it reminds me of the huge responsibility I carry to raise a child who understands his or her actions sometimes can mean life or death.

I wonder about my own teenage son and how I can be assured that he won't commit such a horrendous act. One of the teenagers involved in the incident was reported to be a student who received good grades and worked part-time. Classmates were shocked to discover he participated in such a hateful crime. I'm sure those parents have many questions and wonder, where did we do wrong?

I also wonder, why didn't those guns have trigger locks and why were those dangerous weapons left out so minors could have access to them?

It is reported that the gun used to shoot Jackie belonged to the boyfriend of one of the boy's mother. The Sauk County Sheriff's Department has yet to say whether the guns were locked up or how accessible the guns were to the teens. I certainly hope this situation serves as a reminder to everyone that whether you have children, guns need to be locked up at all times in all homes. Many crimes are committed with guns stolen from the homes of responsible gun owners.

Thomas L. Adams, CAE

It was just over a year ago, when the SMS kicked off its CHILD SAFE campaign. A public safety campaign with a main goal to keep guns out of the reach of children. The campaign was a huge success. Physicians all across this state began or continued asking more frequently, questions about whether their patients had guns in the home. Physicians distributed gun safety checklists, trigger locks, brochures and displayed posters in their office. It was a program that energized our members and I'm proud of the en-

thusiasm CHILD SAFE generated.

But obviously the need for more gun safety education is needed. While CHILD SAFE remains an active program, physician involvement is critical for the program's success. A matching grant program of up to $2,500 remains available for physicians or physician groups that are interested in developing a CHILD SAFE campaign, i.e. distributing trigger locks, brochures or gun safety checklists. CHILD SAFE recently formed its own foundation and physicians are encouraged to call program director James Hoegemeier for information about the project. Members are needed for the CHILD SAFE Board of Directors. Jim can be reached at 1-800-762-8972.

While we continue our fight to educate the public on gun safety, I want to remind our members that everyone on staff at SMS is still in shock over this tragedy. It's difficult to ever imagine that such a terrible incident can hit so close to home. During her 9 years at the SMS, Jackie made many good friends here. As a project coordinator for Lakeside Association Services, Jackie is known as a friendly, conscientious, hardworking and wonderful person. She is a devoted mother to her two college-age sons. While her condition at UW-Hospital remains critical, our thoughts and prayers are with her, her family and friends.

We at the medical society want to keep Wisconsin kids bullet-free and our state CHILD SAFE. Please keep in mind these gun safety tips before, during and after this hunting season:

GUN SAFETY TIPS

AT HOME:

- Use a trigger lock on all guns
- Teach your family gun safety rules
- Make sure the gun is unloaded before you store it
- Store gun and ammunition separately and out of sight and reach of children
- Think about taking a gun safety/hunter safety course
- Consider removing extra guns from your home

WHEN HANDLING A GUN:

- Point it in a safe direction
- Always forbid horseplay
- Never mix drugs and alcohol with weapons
- Follow all safety rules❖

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PROSERVICES

Editorial
Editorial Board briefs

Thomas C. Meyer, medical editor

Early in November the Board spent a half-day fussing and harrumphing over an interesting and varied agenda with key staff members. Fruitful - yes, consensus - no, but entertaining nonetheless.

During the summer, the Board, along with the Society leadership, had re-explored the major functions of the WMJ by means of a Delphi Probe, a convenient mechanism to review, reorder and generate alternatives amongst widely scattered and busy individuals.

The four major functions of the WMJ did not change much, but there was an important change in the priority of each of the functions. Their standing is now:

1. A focus by which Wisconsin physicians may be kept abreast of social, economic, regulatory and environmental issues which are of importance to them.

2. A forum for Wisconsin physicians to discuss medical issues.

3. A journal where Wisconsin physicians can publish scientific articles.

4. A historical record of SMS and its membership.

The change is that the general social, economic, regulatory and environmental issues are now perceived as being the item that draws top attention. The provision of a journal for the publication of articles by Wisconsin authors dropped in listed priority, *but it is clear that the Board will welcome manuscripts from both aspiring and established authors residing in Wisconsin.*

What sort of articles would we like to see? What about case reports with thoughtful discussion? What about some "clinical vignettes" to remind all of us that keeping alert to the bland presentations of complex and fascinating clinical problems is the icing on the intellectual cake of looking after people? What about reporting results of your management of a particular condition and comparing your results with published studies?

Your contributions are always needed and welcomed.❖

Thomas C. Meyer, MD

If Isaac Newton had lived in present-day America.

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Soundings

Images of Danni

Wide eyes,
pupils so large they resemble a style of painting from the '60s
paintings of waifs with oversized eyes staring upward.
Is she looking at me with plaintive eyes,
asking me to do more,
or looking beyond,
wide eyed with wonder, astonished by the glory.

The gentle, rhythmic rise and fall of her chest.
The same rhythmic movements I watched hundreds of times as I
stood in the doorway of my daughter's room at night,
reassured by the movement that everything is okay
and praying that she be watched over in her sleep.
Then my realization broadens, and the rise and fall is from the
gentle caresses of a blue rubber bag by the firm hand of a blue
clad nurse.
Lovingly imparting movement where none exists on its own.

The image of a little girl, crowned with a blonde braid,
laughingly running in and out of the warm summer rain,
which she was just a few short moments ago.

Electricity! Used for intentionally taking the life of society's
most despicable, not its most innocent
The futile attempt to apply very precisely controlled does of the
same electricity that stopped it, across the heart that can no
longer beat on its own.
Hoping to fool the muscle into thinking the impulses are its own
and respond to them.

The blue-black color just under the skin on her temple and feet.
No break in the skin, just the faint foot prints where the demon
that stole her life entered and exited its passing.

The thick smell of sweat
emanating from the hulking bodies. Men sweating from their
exertions in the humid summer's night. The paramedics and
EMTs who, by virtue of their size, make her seem all the smaller.

The single hand of the security guard,
so large it also hides her chest as it provides the false
pulsations that can be felt at her neck,
that teasingly disappear when his hand is removed.
The soft sobbing of her mother, kneeling beside the cart, holding
a limp hand, as the pastor intones a prayer, beseeching God to
protect her and care for her as I have been unable to do.

Then the images blur as my eyes fill with tears.

--Larry E. LaCrosse, MD
Associate Medical Director
Lakeland Medical Center-Elkhorn ❖

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Auscultation of the fetal heart presents advantages over electronic monitoring

Herbert F. Sandmire, MD, and Robert K. DeMott, MD, Green Bay

Currently available data support the conclusion that within specified intervals, intermittent auscultation of fetal heart sounds is equivalent to continuous electronic fetal monitoring (EFM) for detecting intrapartum fetal compromise. One of the disadvantages of EFM is its associated increase in cesarean delivery rates. Patients should receive information on both intermittent auscultation and EFM to enable them to make an informed choice of method for intrapartum fetal assessment. Presently, EFM is routinely used with the majority of laboring patients in the United States. This is likely due to confusion regarding the proper technique used for intermittent auscultation as well as insufficient information about appropriate interventions in the event fetal bradycardia occurs. We have developed a protocol for the performance of intermittent auscultation, including recommended responses to different levels of bradycardia. Intermittent auscultation is simple, provides objective information, and appeals to many well-informed patients. In addition, when the collection of information not relevant to management decisions is eliminated, intermittent auscultation nursing requirements are not greater than with EFM. Laboring patients should receive information on both intermittent auscultation and EFM to enable them to make an informed choice of method for intrapartum fetal assessment. *Wis Med J.1995;94(12):661-663.*

Following review of several research studies, the American College of Obstetricians and Gynecologists (ACOG) Committee on Obstetrics: Maternal and Fetal Medicine reported that "currently available data support the conclusion that within specified intervals, intermittent auscultation of fetal heart sounds is equivalent to continuous electronic fetal monitoring (EFM) for detecting fetal compromise."[1] A distinct disadvantage of EFM is its associated increase in cesarean delivery rates.[2-5] It is appropriate for laboring patients, therefore, to receive information on both intermittent auscultation and EFM to enable them to make an informed choice of method for the intrapartum assessment of their fetus.[6] Despite this ACOG opinion issued 6 years ago, EFM is still routinely used with the majority of laboring patients in the United States.

One of the reasons EFM is used so predominantly results from confusion regarding the proper technique to be used for intermittent auscultation as well as what interventions are appropriate when fetal bradycardia occurs. The belief that a 1:1 nurse patient ratio is required for the auscultation of low-risk patients also discourages use of intermittent auscultation for intrapartum fetal assessment. For clarification of the proper method to be used it is instructive to review the methodology of the research studies[2-5,7-10] leading to the formation of the ACOG opinion. All of those studies required listening only for the first 30 or 60 seconds immediately following a contraction. Additionally the base line rate (between contractions) was determined at unspecified intervals.[2-5,7-10] Fetal heart rate (FHR) abnormalities were defined as:

1) A baseline rate of less than 100 beats per minute;
2) Fewer than 50 beats during the first 30 seconds immediately following three or more consecutive contractions despite such corrective measures as change in position, oxygen administration, correction of hypotension, and

Continued on next page

Drs Sandmire and DeMott are associated with the OB-GYN Associates of Green Bay. Send reprint requests to: Herbert F. Sandmire, MD, OB-GYN Associates of Green Bay, Ltd., 704 South Webster Avenue, Green Bay, WI 54301. Copyright 1995 by the State Medical Society of Wisconsin.

Continued from preceding page

blowing through contractions; and [2,3,10]

3) Irregular heart rate, bradycardia between 100-120 beats per minute and fetal tachycardia.

Patients in the first two categories require evaluation by fetal blood sampling, fetal scalp stimulation, or vibroacoustic stimulation while preparations are made for emergency delivery. In the absence of reassuring findings, delivery is performed as quickly as possible. The third category of abnormalities requires corrective measures and close observation.[2,3,10]

The research studies,[2-5,7-10] serving as the basis for the ACOG opinion, did not involve listening during a contraction, evaluation of the rate of increase of the FHR following a contraction, identification of decelerations, measurement of FHR variability or changing to EFM with the appearance of auscultated FHR abnormalities. Since no research has validated equivalent outcomes with other auscultation protocols, they are not recommended. Despite this the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN—formerly NAACOG) protocol[11] calls for listening during a contraction as well as following a contraction even though that rate is not used for fetal assessment or recommended interventions. The ACOG Technical Bulletin No. 132[1] is cited as the AWHONN reference for listening during a contraction. That same ACOG bulletin however, in another paragraph, recommends listening only following a contraction. Unfortunately listening during a contraction and noting the rate of increase in the FHR following a contraction tempts nursing personnel to "diagnose" decelerations by intermittent auscultation. Since this practice has not been validated by other research studies, was not used in the research studies[2-5,7-10] leading to the ACOG opinion, and engenders nurse anxiety, it is to be discouraged. In addition, by not collecting this useless information, some of the unnecessarily cumbersome AWHONN recommendations for documentation of intermittent auscultation data[11] are eliminated.

Fortunately, ACOG is currently updating its technical bulletin, *Intrapartum Fetal Heart Rate Monitoring*, eliminating the confusion surrounding the timing of auscultation existing currently (Technical Bulletin No. 132).[1] ACOG's Committee on Obstetrics: Maternal and Fetal Medicine recently evaluated this issue in an effort to make an explicit recommendation of guidelines to be followed. They have concluded: "Since the studies referenced in the technical bulletin used the technique of listening to fetal heart rates at least 30 seconds following a contraction, it is the committee's recommendation that this language be used in ACOG and AWHONN documents."[12]

The research studies[2-5,7-10] leading to the ACOG opinion predominantly involved patients with special needs (appendix 1); hence their recommended auscultation interval of 15 minutes during the first stage requiring a 1:1 nurse patient ratio.

For patients without special needs, the ACOG-recommended auscultation interval is 30 minutes during the first stage of labor and every 15 minutes during the second stage. Despite the less frequent auscultation interval, both ACOG[1] and AWHONN[11] recommend a 1:1 nurse patient ratio, even for patients without special needs. No reference sources are cited for this stringent recommendation. We have found the 1:1 ratio to be excessive and believe it inappropriately denies the option of auscultation to some patients. Through experience, we have further simplified the protocol by eliminating the need to ascertain base line rate if the number of beats in the first 30 seconds following a contraction totals between 60-80 (120-160 beats per minute). This change followed our continuous observations that having 60-80 heartbeats in the first post-contraction 30 seconds was never associated with a baseline <100 or >180. With the use of our simplified FHR form (appendix 2), the recording of relevant information is significantly less time intensive than the ACOG-recommended EFM evaluation, interpre-

Table 1.- Special needs patients*

Antepartum complications	Intrapartum complications
Preeclampsia	Abruptio placentae
Hypertension	Placenta previa
Multiple pregnancy	Meconium-moderate or thick
Post-term (>42 wk)	Abnormal fetal heart rate
Preterm (<37 wk)	Preeclampsia
Breech	Protracted or arrested dilation
Maternal heart disease	Protracted or arrested descent
Abruptio placentae	Multiple pregnancy
Placenta previa	
Previous stillborn	
Meconium-moderate or thick	
Diabetes (including gestational)	
Chronic renal disease	
Drug addiction	
Isoimmunization	

* Patients requiring fetal heart rate assessment at 15- and 5-minute intervals in the first and second stages, respectively. Research studies demonstrating the safety of auscultation for previous-cesarean patients are not available; therefore, continuous electronic fetal monitoring is used.

tation and recording of baseline rate and variability, periodic changes, and trends over time.[1] The time requirement for recording that information is substantially increased by the presence of one or more abnormalities prevailing on 91% of EFM strips.[13]

Conclusion

In summary, electronic fetal heart rate strip interpretation is complicated, associated with inter-and intra-observer variation,[14,15] and is no more predictive of fetal and newborn condition or long-term neurologic disorders than is intermittent auscultation.[2-5,7-10] An additional disadvantage to the laboring patient is the EFM-associated increase in cesarean delivery rates.[2-5] Intermittent auscultation is simple, provides more objective information and appeals to many well-informed patients. Additionally when the collection of information not relevant to management decisions is eliminated, intermittent auscultation nursing requirements are no greater than with EFM. Withholding information on the availability of intermittent auscultation deprives patients of useful information needed for making an informed choice for the intrapartum assessment of their fetus.

Table 2 - Chart for fetal heart rate auscultation observations used by Bellin Hospital.

Bellin Hospital

FETAL HEART RATE AUSCULTATION OBSERVATIONS

Labor Status - L = Latent A = Active 2 = 2nd Stage

Date/Time	FHR 30 Sec.	FHR 60 Sec.	Labor Status	RN Signature	Comments
					time

10-6799.16a

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High dose methotrexate infusion with leucovorin rescue for treatment of ectopic pregnancy

Dale M. Larson, MD; Stuart J. Tipping, MD; Gerald M. Mulligan, MD; Kenita K. Johnson, PA; and Jan Becker, RN, Marshfield

The purpose of this article is to evaluate the effectiveness, side effects, and complications of high dose methotrexate infusion with leucovorin rescue in select patients with ectopic pregnancy. Between January 1991 and November 1994, 28 patients with ectopic pregnancies were prospectively treated with methotrexate (100 mg/m^2 intravenous bolus followed by a 200 mg/m^2 infusion over six hours) with leucovorin rescue. Twenty-seven of 28 patients (96%) were successfully treated. Only one patient (4%) required a second course of methotrexate to reach a normal hCG titer. One patient failed methotrexate infusion 45 days after treatment at a hCG titer of 12 mIU/mL. No Gynecologic Oncology Group grade 3 or 4 clinical, biochemical or hematologic toxicities occurred. Uterine bleeding and abdominal pain, not requiring transfusion or hospitalization, occurred in 71% and 56% of patients. The authors conclude that high dose methotrexate infusion with leucovorin rescue is a highly effective, well tolerated, nonsurgical treatment for select patients with ectopic pregnancy.
Wis Med J. 1995;94(12):664-667.

Over the past 20 years, the management of ectopic pregnancies has evolved to less invasive therapy. Laparoscopic procedures have replaced most laparotomies. And recently, nonsurgical management with chemotherapeutic agents has replaced many laparoscopic procedures.[1] While several chemotherapeutic agents have been effective in treating ectopic pregnancies[5] methotrexate has been the most extensively evaluated.[6-11] Initial reports using methotrexate required patients to receive multiple doses over several days.[6,7] Recent reports have administered a single dose of methotrexate with varying success.[8-11] In this manuscript, we review our experience with a 1-day high dose methotrexate infusion and leucovorin rescue for outpatient, nonsurgical management of ectopic pregnancy.

Drs Larson, Tipping and Mulligan as well as Johnson and Becker are with Marshfield Clinic, working in the departments of obstetrics and gynecology, clinical oncology, and radiology. Address reprint requests to Dale M. Larson, MD, 1000 North Oak Avenue, Marshfield, WI 54449. Copyright 1995 by the State Medical Society of Wisconsin.

Methods

Between January 1991 and November 1994, women with ectopic pregnancies seeking medical treatment at the Department of Obstetrics and Gynecology at the Marshfield Clinic were offered nonsurgical options. Patients who wished to be considered for nonsurgical treatment were also counseled concerning surgical and nonsurgical options and were screened for eligibility. Patients were deemed eligible for nonsurgical treatment if (1) they were asymptomatic or minimally symptomatic, (2) they were hemodynamically stable, (3) quantitative beta hCG titer was less than 7,500 mIU/mL, (4) transvaginal ultrasound revealed a tubal mass less than 3.5 cm in diameter, (5) the patient consented to the risks of methotrexate therapy including myelosuppression, stomatitis, nausea and vomiting, renal or hepatic dysfunction, (6) the patient agreed to follow-up examinations with frequent beta hCG testing, (7) the patient agreed to remain within a 50-mile radius of the treatment center until the beta hCG level was less than 5 mIU/mL, and (8) the patient agreed to use a reliable method of birth control and not attempt pregnancy until 3 months following methotrexate treatment.

Patients were not considered eligible for methotrexate infusion if (1) they had significant abdominal discomfort suggesting impending rupture, (2) they were hemodynamically unstable, (3) transvaginal ultrasound revealed an adnexal mass greater than 3.5 cm in diameter or significant pelvic hemorrhage, (4) they had evidence of hepatic dysfunction (aspartate amino transferase >two times the upper limit of normal), (5) they had evidence of renal insufficiency (serum creatinine >1.5 mg/dL), (6) they had evidence of leukopenia (white blood count < 2,000 x 10^3/mL) or (7) they had evidence of thrombocytopenia (platelet count < 100,000 x 10^3/mL).

Patients were treated at the Marshfield Clinic Outpatient Chemotherapy Center according to a standard protocol. On weekends and holidays, patients were admitted to the hospital overnight. Methotrexate was administered as a 100 mg/m^2 intravenous bolus followed by a 200 mg/m^2 infusion over 6 hours. Twenty-four hours after the methotrexate bolus, leucovorin 15 mg orally every 12 hours for four doses, was initiated. A quantitative beta hCG titer was obtained every Monday, Wednesday, and Friday until the patient's beta hCG titer was less than 5 mIU/mL. Patients were reevaluated 7 and 14 days after treatment with history and physical examination including pelvic exam,

white blood count (WBC), hemoglobin, platelet count, creatinine, and aspartate amino transferase. Clinical, biochemical, and hematologic toxicities were graded according to the Gynecologic Oncology Group common toxicity criteria.[12] Three months after successful methotrexate infusion patients were reevaluated by their referring physician concerning future pregnancy options.

Statistical analysis included mean values expressed as ±1 standard deviation (SD).

Results

Between January 1991 and November 1994, 28 women diagnosed as having ectopic pregnancies were treated with methotrexate infusion at the Marshfield Clinic. Twenty-two (79%) received methotrexate as an outpatient, six (21%) were hospitalized. The mean age was 29.5 ± 5.9 years (range 20-38), the mean gravity was 3.1 ± 2.0 (range 1-8), and the mean parity was 0.9 ± 1.3 (range 0-5). Fifteen patients (54%) had a history of prior fallopian tube surgery including 10 women (36%) with prior laparotomies for ectopic pregnancies. Seven had a history of one prior ectopic pregnancy, one had two, and two had three. Six patients (21%) had a past history of pelvic inflammatory disease.

The mean pretreatment beta hCG titer was 1244 ± 1414 mIU/mL with a median of 644 mIU/mL (range 114-6490 mIU/mL). Pretreatment symptoms included abnormal uterine bleeding in 10 patients (36%), abnormal uterine bleeding and mild lower abdominal pain in 13 (46%), and mild lower abdominal pain without uterine bleeding in one (4%). Four patients (14%) were asymptomatic.

Transvaginal ultrasound diagnosed the size and location of the ectopic pregnancy in 22 of the 27 women (81%) scanned prior to treatment. One patient with a rising beta hCG titer after laparoscopic salpingostomy did not have a pretreatment ultrasound.

Fetal cardiac activity was not identified in any of the ectopic pregnancies treated. The five women treated without the site of ectopic pregnancy identified on ultrasound or laparoscopy included one with a hCG titer of 6490 mIU/mL and no intrauterine pregnancy on ultrasound, three with hCG titers of 332, 141 and 114 mIU/mL had a less than 60% increase in hCG titer over 48 hours and not declining, and one with a hCG of 244 mIU/mL had a less than 60% increase over 48 hours and no villi on endometrial curettage.

Twenty-seven of 28 women (96%) were successfully treated with methotrexate infusion. Of the successfully treated women, 26 (96%) had a single course of methotrexate. One patient experienced a plateau in her hCG titer 2 weeks after treatment and was successfully retreated with a second infusion. One patient (4%) failed methotrexate infusion. Her pretreatment hCG was 3670 mIU/mL and pelvic ultrasound showed a right-sided ectopic pregnancy 10 mm in diameter with no fluid in the cul-de-sac. Forty-five days after a single methotrexate infusion she experienced severe acute abdominal pain and had a hCG titer of 12 mIU/mL. Surgical exploration revealed a 500 mL hemoperitoneum with active bleeding from the right fallopian tube. Final histopathology revealed viable trophoblastic tissue with hemorrhage involving the distal fallopian tube.

Table 1 summarizes the side effects experienced by the 28 women following methotrexate infusion. One, who had a history of pelvic inflammatory disease, experienced

Continued on next page

Table 1 - Side effects of high dose methotrexate infusion (N = 28)

	Gynecologic Oncology Group Toxicity Grade (%)				
Toxicity	**None (0)**	**Mild (1)**	**Moderate (2)**	**Severe (3)**	**Life Threatening (4)**
Nausea	16 (57%)	8 (29%)	4 (14%)	0 ---	0 ---
Vomiting	26 (93%)	1 (4%)	1 (4%)	0 ---	0 ---
Stomatitis	24 (86%)	4 (14%)	0 ---	0 ---	0 ---
Skin Reaction	28 (100%)	0 ---	0 ---	0 ---	0 ---
Alopecia	28 (100%)	0 ---	0 ---	0 ---	0 ---
Hypotension	27 (96%)	1 (4%)	0 ---	0 ---	0 ---
Infection	26 (93%)	1 (4%)	1 (4%)	0 ---	0 ---
Leukopenia	24 (86%)	3 (11%)	1 (4%)	0 ---	0 ---
Thrombocytopenia	22 (79%)	6 (21%)	0 ---	0 ---	0 ---
Anemia	14 (50%)	12 (43%)	2 (7%)	0 ---	0 ---
Creatinine	19 (68%)	9 (32%)	0 ---	0 ---	0 ---
SGOT/AST	22 (79%)	5 (18%)	1 (4%)	0 ---	0 ---

Continued from preceding page
severe pelvic pain 5 days after methotrexate infusion. She was febrile and had a WBC of 12.5 x 10^3/pL. Ultrasound revealed no evidence for intra-abdominal hemorrhage. She was hospitalized with a diagnosis of recurrent pelvic inflammatory disease, was treated with intravenous antibiotics, had prompt resolution of her symptoms, and was discharged 4 days later.

Another patient developed a productive cough with fever seven days after methotrexate infusion. Her WBC was 3.5 x 10^3/pL. Chest x-ray revealed pneumonitis. She was successfully treated with oral antibiotics as an outpatient. One patient experienced two separate vasovagal reactions, 1 and 2 days after the methotrexate infusion. She was hemodynamically stable with an unchanged hemoglobin level. No treatment was rendered and the symptoms did not recur. Patients who experienced grade 2 toxicity included one with controlled vomiting for 7 days, one with a nadir WBC of 2.7 x 10^3/pL, two with nadir hemoglobins of 9.8 and 9.1 g/dL , and one with a transient aspartate amino transferase elevation to 115 u/L seven days after treatment which returned to normal on day 14. No patients experienced grade 3 or 4 toxicity. Twenty women (71%) experienced intermittent uterine bleeding which persisted until their hCG titers returned to normal. Fifteen of the 27 successfully treated patients (56%) experienced lower abdominal cramping and discomfort after the methotrexate infusion. Four patients experienced severe abdominal discomfort, necessitating pelvic ultrasound 2, 5, 5, and 5 days after methotrexate infusion. None of these patients required hospitalization.

Table 2 summarizes the hematologic, renal, and hepatic parameters prior to, and seven and 14 days after methotrexate infusion. No patients experienced clinically significant anemia, leukopenia, thrombocytopenia, hepatic or renal dysfunction. No blood transfusions were administered.

Nine women (32%) had evaluation for tubal patency 3 months after methotrexate infusion - three had hysterosalpingograms, six had laparoscopic tubal dye studies. Five patients (56%) had a patent fallopian tube identified on the same side as the ectopic pregnancy was diagnosed by ultrasound.

Overall, 18 women (64%) have attempted pregnancy following methotrexate infusion. Seven (39%) have not conceived, four (22%) had ectopic pregnancies, and seven (39%) had intrauterine pregnancies including five with full term deliveries, one with an ongoing intrauterine pregnancy at 22 weeks gestation, and one with a first trimester spontaneous abortion.

Discussion

Tanaka et al[13] first reported the use of systemic methotrexate for treatment of an interstitial ectopic pregnancy in 1982. Ory et al[6] subsequently reported the successful treatment of five patients with multidose methotrexate and leucovorin administered over 8 days. In 1991, Stovall et al[7] reported a 96% success rate in 100 patients who received an eight day regimen of methotrexate and leucovorin. More recently, Stovall et al[9] and Henry and Gentry[10] reported their experiences with a single dose of methotrexate. Stovall et al[9] administered a single 50 mg/m^2 intramuscular injection of methotrexate without leucovorin rescue. Three percent of their patients required a second treatment course. Ninety-five percent of their patients were successfully treated. Henry and Gentry[10] also administered a single 50 mg/m^2 intramuscular injection of methotrexate without leucovorin rescue. However, 26% of their patients required a second injection because of rising or plateauing hCG titers. Overall, 85% of their patients were successfully treated. Our success rate of 96% with 4% of patients requiring a second treatment course with high dose methotrexate infusion is similar to the experience of Stovall and Ling[9] with intramuscular methotrexate.

While Stovall and Ling[9] and Henry and Gentry[10] did not detail the clinical, hematologic, renal and hepatic toxicities experienced by their patients treated with methotrexate for ectopic pregnancies, Homesley et al[14] reported the experience of the Gynecologic Oncology Group with intramuscular methotrexate (30 to 50 mg/m^2) in patients with nonmetastatic gestational trophoblastic disease. While Homesley et al[14] reported no grade 3 or 4 toxicities in their patients, 20% experienced mild to moderate hematologic toxicity, 20% experienced nausea, and 11% had controlled vomiting. These findings in patients who received low dose methotrexate are similar to the type, frequency, and severity of toxicities our patients experienced with high dose methotrexate infusion.

In our experience, women were more likely to experience symptoms from involution of the ectopic pregnancy than side effects from methotrexate. Uterine bleeding occurred in most women and persisted until their hCG titer returned to normal. In our patients, the uterine bleeding was not excessive and no intervention was required. While more than half of our patients experienced abdominal discomfort, the intensity was usually mild. In the few patients who developed severe abdominal pain, pelvic ultrasound excluded intra-abdominal hemorrhage and allowed for supportive management without surgery.

While Stovall and Ling[9] recommended following hCG titers until less than or equal to 12 mIU/mL, the only patient in our series who failed treatment developed symptoms at a hCG titer of 12 mIU/mL, some 45 days after methotrexate infusion. Patients who have had a significant fall in their hCG titer are still at risk for

intra-abdominal hemorrhage and should be followed closely until their hCG titer is within normal limits.

Our high-dose methotrexate infusion trial was initiated prior to the reports of Stovall and Ling[9] and Henry and Gentry[10] using single injection low dose methotrexate. In our experience, the high-dose methotrexate infusion has been a highly effective, well tolerated, nonsurgical alternative for management of select patients with ectopic pregnancies. A prospective randomized trial is needed to compare the effectiveness, side effects, complications, and total treatment cost of high dose methotrexate infusion and low-dose intramuscular methotrexate in patients with ectopic pregnancy.

Table 2 - Hematologic, renal, and hepatic parameters prior to, and seven and 14 days after methotrexate infusion.

	Days After Methotrexate Infusion		
	Pretreatment	7	14
Hemoglobin (g/dL)			
Mean	13.04	12.13	12.12
SD	1.36	1.42	1.31
Range	10.0-16.5	9.5-15.5	9.1-15.3
White Blood Count (x 10^3/μL)			
Mean	8.5	6.1	6.9
SD	2.6	1.9	1.8
Range	4.6-13.1	2.7-9.8	4.5-10.4
Platelet Count (x 10^3/μL)			
Mean	294	260	307
SD	67.6	64.8	70.7
Range	199-440	105-372	199-443
Creatinine (mg/dL)			
Mean	.89	.98	.95
SD	.13	.12	.10
Range	.6-1.2	.8-1.3	.7-1.1
Aspartate Amino Transferase (U/L)			
Mean	15.3	23.7	16.4
SD	6.1	21.3	6.2
Range	6-34	8-115	7-33
Normal Laboratory Value"			
Hemoglobin (g/dl)		11.7 - 15.5	
White blood count (x 10^3 μ/L)		4.1 - 10.9	
Platelet count (x 10^3 μ/L)		175 - 450	
Creatinine (mg/dl)		0.5 - 1.2	
Aspartate Amino Ttansferase (μ/L)		8 - 36	

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The time has come for the medical management of ectopic pregnancy

Julian C. Schink, MD, Madison

In this issue of *WMJ*, Dr Dale Larson and his colleagues at the Marshfield Clinic describe their excellent clinical results using methotrexate chemotherapy as treatment for ectopic pregnancy. Since the introduction of methotrexate for the treatment of gestational trophoblastic disease by Li et al[1] in 1956, choriocarcinoma has evolved from one of the most fatal to one of the most curable of human malignancies. Choriocarcinoma was the first solid tumor cured with chemotherapy. Choriocarcinoma is rare, occurring in only one out of every 40,000 pregnancies. On the other hand the treatment Dr Larson describes is for ectopic pregnancy, a common problem occurring in one of every 200 pregnancies. An improvement in the management of this relatively common pregnancy complication represents an important advance in medical care of all reproductive age women.

The use of chemotherapy drugs to treat a benign condition should cause us to pause and ask why use these powerful drugs for a "benign" condition? Almost 40 years of experience using methotrexate in the treatment of gestational trophoblastic disease (GTD) has shown this drug to be safe. In women treated for GTD with methotrexate alone there has been no increased risk of leukemia, or increase in the complications or malformations of subsequent pregnancies. The incidence of ectopic pregnancy has increased five fold in the last 25 years. In 1987 the United States Center for Disease Control (CDC) reported 88,000 ectopic pregnancies. The traditional treatment for this increasingly common problem of ectopic (tubal) pregnancy is surgery. Thousands of Wisconsin women stand to benefit from this medical alternative, a new approach that may spare them the morbidity, cost, and pain of a surgical treatment.

Ectopic pregnancy results from implantation of the embryo outside the uterine corpus, 98% of ectopic pregnancies are in the fallopian tube. Implantation within the fallopian tube is thought to result from delayed migration of the oocyte or embryo through the tube. Abnormal tubal transport can result from the structural changes associated with intrauterine DES exposure. Most often the abnormal fallopian tube is from adhesions within or surrounding the tube, usually the consequence of prior tubal infection. The increased incidence of ectopic pregnancy probably reflects societal changes of the '70s and '80s, with liberalized personal values, and delayed child bearing, the likelihood of silent tubal infection is greater. Chlamydia, the sexually transmitted disease of the '70s, causes few symptoms but significant tubal damage. It is to be hoped that the sexual behavior that leads to tubal infection and other sexually transmitted diseases will diminish in coming years and the incidence of ectopic gestation will decrease.

The medical treatment of ectopic pregnancy is safest and most effective in early pregnancy. Improvement in the ultrasound diagnosis of tubal pregnancy has played a critical role in the evolution of this medical management. The failure of medical treatment is associated with HCG levels greater than 10,000 IU/L, or a gestational sac larger than 4cm, or if a fetal heart beat is noted.[2] Since early diagnosis of ectopic pregnancy may help your patient avoid surgery a heightened vigilance in patients at risk is warranted. These risk factors include a history of salpingitis, tubal surgery, DES exposure, or prior ectopic pregnancy. Serially HCG levels increasing less than 66% in 48 hours are predictive of ectopic gestation or intrauterine pregnancy destined to abort in 87% of cases.[3] A single serum progesterone level below 15 ng/ml in the first 6 weeks gestation is commonly associated with ectopic gestation and spontaneous abortion.[4] Transvaginal ultrasound may detect an intrauterine gestational sac as early as 35 days gestation or when the HCG level is 1400. I advocate preconception counseling regarding the signs and symptoms of ectopic pregnancy and early gestational screening for patients with risk factors. To screen for ectopic pregnancy a woman should be seen 35 to 38 days after their last menstrual period and evaluated with an HCG level, progesterone level, and transvaginal ultrasound. If the patient is treated with methotrexate chemotherapy for an ectopic pregnancy, like any other pregnancy loss, her Rh status should be evaluated and treatment rendered if she is Rh negative.

Dr Larson and his colleagues have described a highly effective treatment regimen that can be offered to two thirds of women with tubal pregnancy, allowing these women the opportunity to avoid a major abdominal surgery. The medi-

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cal management of ectopic gestation requires experience managing ectopic pregnancy and a familiarity with the use of methotrexate chemotherapy. Since most clinicians do not have this combined experience a team approach may be necessary, this team should include a gynecologist, an oncologist, and a chemotherapy certified nurse. Close follow up of these patients is required as 3 to 4% of medically treated tubal pregnancies will rupture. A declining HCG level does not eliminate the risk of rupture, nor does an HCG level below 100, as evidenced by Dr Larson's article. The medical management of ectopic pregnancy is an important step forward in the treatment of this increasingly common illness.

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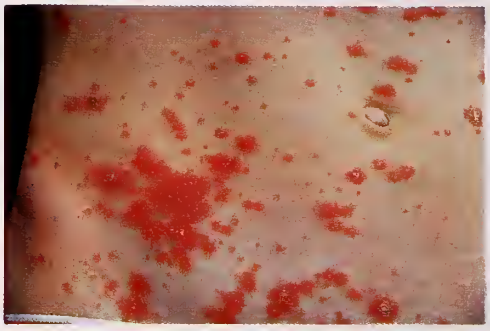

This previously healthy 13 year old boy has had this very scaly, slowly spreading rash for 2 weeks. The rash doesn't itch and the patient is otherwise completely asymptomatic.

I. What is the rash?
- a. Guttate psoriasis
- b. Tinea corporis
- c. Pityriasis rosea
- d. Eczema

II. What further tests would be appropriate?
- a. Urinalysis
- b. Skin biopsy
- c. Throat culture
- d. CBC

This series is provided courtesy of Gary L. Williams, MD, Department of Pediatrics, University of Wisconsin.

These pictures, along with Dr. Williams' comments will appear in the February *WMJ*, along with a new set of pictures.

WMJ IS SOLICITING PICTURES OF SIMILAR INTERESTING PRIMARY CARE CASES FROM THE MEMBERSHIP. THEY WILL BE ACKNOWLEDGED IF PRINTED AND THE SLIDES RETURNED - HONESTLY!

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- ❑ d. Eczema

II. What further tests would be appropriate?
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Meyer's note:

The winning entry will be selected by Shari Hamilton, *WMJ* staff editor, randomly from all correct CCC forms returned with 14 days of *WMJ* mailing. Shari's ethics ensure greater fairness than bonded accountant firms.

October CCC winner

Question

Each of these previously healthy two teen-age males has had a lesion in his mouth for approximately 2 weeks. Neither patient smokes or chews tobacco, each feels perfectly well otherwise. The lesions are each solitary, painless and bleed easily. Each patient has the same lesion, what is it?

a. Squamous cell carcinoma
b. Enterovirus infection
c. Herpes simplex infection
d. Pyogenic granuloma

Answer

The answer is **D.** Pyogenic granuloma. Pyogenic granuloma are small vascular nodules which are quite common. They appear quite rapidly and bleed easily; the precipitating cause is not known. Though they appear most commonly on the skin, they may also appear on the mucus membranes of the mouth, as they did in these patients. Though the lesions are benign, they do not regress spontaneously and are best removed by laser surgery or electrodesiccation and curettage.

Winner

Leo K. Young, MD, of Wausau, was the very first recipient of CCC gourmet cookies. Dr Young is a family practitioner and earned his medical degree at the University of Hawaii in 1993.

Proceedings of the 1995 Wisconsin Primary Care Research Forum

The Ninth Annual Meeting of the Wisconsin Research Network (WReN), the 1995 Wisconsin Primary Care Research Forum, was held Sept 29-30, 1995 in Wausau, Wisconsin. WReN, a statewide network of more than 600 primary care professionals interested in practice-based research, is organized under the auspices of the Wisconsin Academy of Family Physicians (WAFP) Research Committee and is supported by the WAFP and the Wisconsin Institute of Family Medicine (WIFM). This 2-day conference is planned as a working meeting for the participants. It includes presentations by invited speakers, original research by primary health care professionals and workshops related to conducting research in the office setting. The following abstracts represent presentations on original research. (From the Wisconsin Research Network. Contact: John Beasley, MD, WReN Director, 777 S. Mills Street, Madison, WI 53715.) Copyright 1995 by the State Medical Society of Wisconsin.

Recruitment of primary care practices for a clinical trial

P. McBride, MD, MPH*, K. Massoth, MS*, L. Solberg, MD**, L. Ellis, RD**, H. Schrott, MD***, K. Smith, RD***, J Strauman, RN, MBA, MS*, G. Underbakke, RD, MS*, MB. Plane, PhD*

Successful methods for recruiting private primary care practices are important to the future of primary care research. Recruiting practices for participation in trials to increase practice preventive services is a daunting task, but important lessons have been learned to make the process more efficient. We will describe three different methods used in three regions of the Midwest to recruit 45 practices for the Health Education and Research Trial (HEART), a clinical trial of four interventions to improve heart disease preventive services. The methods include: (1) a mailing to all area practicing primary care physicians with a postcard return, follow-up phone call to responders, and recruitment visits to eligible practices; (2) a mailing to medical directors of practices in an HMO provider network with phone follow-up; and (3) a medical director mailing to randomly selected practices (prescreened for eligibility) with phone follow-up and recruitment visits to interested practices. All three methods used practice-site presentations to inform about the trial and to finalize a contract. The widespread mailing response for Method 1 was very low (3%), but physicians who responded were very likely to enter the trial (14/16, 88%). The other two methods had high response rates (46% and 93%) and high entry (58% and 78%) rates. Protocols, response rates, acceptance rates, utility, costs, and yield of the recruitment techniques will be presented to discuss useful strategies to recruit practices.

*Note: * University of Wisconsin, **Health Partners, Minneapolis, Minnesota, ***University of Iowa.* ❖

Relationship between serum cholesterol and hematocrit

Jonathan L. Temte, MD, PhD, and Kathy Duesterbeck, MLT-ASCP, Madison

THE REPORT OF THE US Preventive Services Task Force recommends periodic evaluation of serum cholesterol level in adults. In contrast, routine screening of hematocrit is not recommended except in pregnant women and infants. Serum cholesterol level and hematocrit have been shown to be significantly correlated. This correlation was based upon study of 200 elderly, hypertensive males at the Veterans Hospital in Milwaukee. To assess whether this correlation was generalizable to a family practice clinic, we investigated the relationship between serum cholesterol and hematocrit in a community practice setting.

Blood specimens were collected on an opportunistic basis from patients at Wingra Family Medical Center in Madison over a 16-month period. Hematocrit and serum cholesterol levels for individuals were determined on the same blood specimen. Following exclusions for medical conditions and medications, values from 285 patients were available for analysis. A hypothetical relationship between serum cholesterol and hematocrit, based on dilution of cholesterol in the serum pool, was tested using multiple linear regression following adjustment for age and sex. Finally, this model based upon community patients was compared to one based on data obtained from the Milwaukee VA study using analysis of covariance.

The mean serum cholesterol level and hematocrit in 285 Wingra patients were 189.6 mg/dl and 41.6%, respectively. These were significantly lower than the VA mean values of 224.8 mg/dl and 45.0%. In addition, the age and sex distributions of the two groups were significantly different (mean age: 40.0 vs 61.4 years; 66.7% female vs. 98.4% male). Serum cholesterol increased 2.6 mg/dl for each percentage increase of hematocrit. A more specific dilutional model was found to be supported by the data. Moreover, no significant differences were found to exist in the hematocrit:cholesterol relationship between clinical populations.

Despite vast differences of age and sex among study populations, correlation exists between serum cholesterol and hematocrit for both populations. This correlation may best be explained by a simple dilutional relationship. This relationship appears to be maintained across wide ranges of hematocrit. Consequently, alterations in hematocrit may significantly affect serum cholesterol levels and have some bearing on cardiovascular risk.❖

Barriers to discussions about sexual topics with adolescent patients reported by Wisconsin family physicians

Mickey Harris, PhD and Mike Menen, Milwaukee

THE PURPOSE OF THIS study was to examine the content and structure of physician-adolescent patient discussions about sexual matters among Wisconsin family physicians and to describe the physician-related barriers to conducting these discussions. In 1990 in the US, almost 13 million adolescents between the ages of 12 and 19 (60% girls, 75% boys) reported having sexual intercourse by the time they graduate from high school, with younger adolescents (12 to 14 years of age) showing a higher rate of increase in sexual activity. Parents and their adolescent children have identified primary care physicians as an important source of information about sexual behavior and the relationship between sex and health. Little is known, however, about the quality and effectiveness of physician-based interventions aimed at reducing sexual risk factors for adolescents. Current research suggests that (1) physicians often appear uncomfortable when talking to adolescents about sex; (2) adolescent patients and their parents often describe physicians as mechanical and unapproachable when discussing sexual topics; (3) physicians generally rely on personal experience for these discussions; and (4) reviews of adolescent patient records reveal consistent absences of sexual histories.

A self-report questionnaire was developed, validated, and mailed to the 1,100 active members of the Wisconsin Academy of Family Physicians. Physicians were surveyed for descriptions of their practice, the number of adolescent patients, perceived necessity of providing education about sexual matters and of

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taking sexual histories, and the perceived influences on physician comfort levels with these discussions.

The survey was completed and anonymously returned by 222 (20.5%) of the physicians. Participants in the study acknowledged the necessity (48% always, 42% often) of discussing sexual matters and of taking sexual histories with their adolescent patients. It was not, however, seen to be as important to follow up on sexual activity of the adolescent patient (25% always, 74% often). Physicians also indicated that they, not the patient, were primarily responsible for initiating these discussions and the format was an informal one supplemented with reading materials such as pamphlets. There was a noticeable lack of participation in these discussions of other clinic personnel. Respondents acknowledged the influence of personal (physician) philosophy and clinical experience. The presence of one or more parents in the discussion was an important influence on physician comfort with taking sexual histories (80%) and conducting sexual education (68%). The physicians' religious views, their perception of societal views, legal concerns, and the risk of promoting negative sexual behavior were not considered influential on the physicians' comfort level. Physicians tended to be more uncomfortable as the patient age decreased and were most uncomfortable with patients 12 years of age. Their discomfort increased as the physician-patient age difference increased. Physicians were more comfortable discussing sexually related topics with patients of their own gender.

These results have important implications for the continuity, variability, and effectiveness of the encounters related to sexual topics family physicians have with adolescent patients. Physicians in the study sample tended to be the primary clinic discussant and relied on informal talks heavily influenced by the diverse and subjective factors of philosophy and experience and presence of a parent. This variability is potentially compounded by considerations of the amount of time physicians are typically able to spend with adolescent patients. The influence of the parents needs to be explored further as well as the impact of same versus opposite physician and patient gender. Below the patient age of 14 years physicians' discomfort rises dramatically just at an age when sexual education and history-taking are becoming increasingly important. These results encourage consideration of (1) more formal adolescent patient sexual education; (2) the value of involving other non-physician clinic personnel in this education; and (3) physician and medical student education focusing on adolescent patient sexual discussions.

Mike Menen is a medical student at the Medical College of Wisconsin.

Are the low rates of heart disease risk factor screening in primary care practices a failure to document?

Patrick McBride, MD, Mary Beth Plane, PhD, Gail Underbakke, RD, Greg Pfiefer, BA, Roger Brown, PhD, Madison

The Health Education and Research Trial (HEART) is a 5 year NIH-sponsored clinical trial to study methods to improve heart disease preventive services in primary care practices. Baseline data from 45 private practices in four Midwestern states, including 160 physicians and 388 practice staff, was collected from medical records, physician estimates, and patient reports of services provided, risk factors, and health status (n=8023). Medical records were audited by trained auditors with 100% quality checking and double data entry to ensure accuracy. Sixty-one percent of records have a smoking history, while 72% of patients recall a physician asking about smoking; 74% of patients who currently smoked reported physician advice to stop smoking, and 58% reported setting a quit date, but only 45% of records documented any advice. Seventy-seven percent of records have a cholesterol level drawn in the past 5 years, but 38% of patients were unaware of their cholesterol or misstated the result. In addition, 72% of patients surveyed report a family history of heart disease, while only 42% of records contain that history. Similar discrepancies exist between medical records and patient reports for counseling or advice, while high correlations are noted for laboratory services or prescriptions, suggesting that the patient report data is reliable. However, even when using patient reports, screening and management of heart disease risk factors remains below national standards or standards set by the physicians themselves. These results indicate poor reliability of medical records for screening and counseling, but excellent validity for labs and medications. Practice research on preventive services must utilize several sources for data and not rely on single sources.❖

Over-the-counter products containing theophylline can cause theophylline toxicity

Len Scarpinato, DO, FCCP, and D. Purdom, MD, Milwaukee

Introduction

Toxic effects are a well-known complication of an overdosage of prescription theophylline. What is less known is that over-the-counter (OTC) asthma medications contain theophylline, and that in some cases this might cause toxic effects. A case seen by us involved toxic effects from theophylline in an OTC medication and to date is the only published case (Scarpinato L & Purdom D. *Arch Fam Med* 1993; 2:1081-1083). The rationale for this study was to delineate the OTC products containing theophylline from whatever data sources available.

Methods

Multiple computer searches via MEDLINE were done. A Freedom of Information Act request was sent to the FDA on adverse reports and reactions associated with the use of theophylline. The American Association of Poison Control Centers was contacted.

Results

The MEDLINE computer searches failed to reveal any previous reports of toxic effects of theophylline from an OTC medications. The Freedom of Information response from the FDA stated that, since companies that marketed OTC medications are not required to keep a record of adverse effects, there were none reported to the FDA. The American Association of Poison Control Centers recorded 5,735 cases of unintentional theophylline exposure in 1992. These were not coded as OTC vs. prescription, so the incidence of unintentional OTC exposure is unknown. Perusing several pharmacology texts and the PDR, 15 OTC products contain theophylline in ranges of 45 mg - 177 mg.

Conclusions

OTC products containing theophylline can cause theophylline toxicity, but no reporting mechanism exists. There are minimal publications documenting this. Information is not readily available on this topic. At least one documented case has been published.❖

Critically ill obstetric patients: Outcomes and predictability utilizing the SAPS II score in a 314 bed community hospital

Len Scarpinato, DO, FCCP, Milwaukee

Introduction

Critically ill obstetric patients have neither been actively excluded or included in the development or validation of ICU scoring systems. Initial reports indicated APACHE II scores underestimated actual mortality in university hospital critically ill obstetric patients (Koch KA et al. Abstr. Crit Care Med 1988; 16:409). Yet recent literature with a larger data set indicates that APACHE II can overestimate the predicted mortality rate of these patients (Lewinsohn et al. *Crit Care Med* 1994; 22:1412-1414). No data exist regarding the SAPS II score in the critically ill obstetric population, nor in the community hospital setting.

Methods

Using multiple computer billing surveys as well as hospital service transfer records, all 31 critically ill obstetric patients were identified during the period Oct 1989-Oct 94. All available charts were pulled and reviewed for appropriateness of inclusion into the data set (N=16). A new simplified acute physiology score (SAPS II) was calculated on all (aged 15-39, average age 27) and compared to 19 nonpregnant female controls (aged 15-49, average age 38.4) seen Dec 94-Feb 95 and April 95, as well as an all age, nonpregnant female control (average age 57). Mortality data were collected.

Results

Average SAPS II score on the 16 obstetric critical care patients was 18, corresponding to a mortality risk of 3%; actual mortality was 0%. An all age nonpregnant female patient control of 33 patients had an average SAPS II score of 27, corresponding to a mortality risk of 9%; actual mortality was 3.1%. A 15-49 year old nonpregnant female control of 19

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patients had an average SAPS II score of 20.4, corresponding to a mortality risk of 4%; actual mortality was 0%. Utilizing the STATA™ statistical analysis package, the two-sided test indicated P=.5 and therefore these numbers were not statistically significant.

Conclusions
Obstetrical patients requiring intensive care in our community hospital Med/Surg ICU had a better outcome than predicted by the SAPS II score, but it was not statistically significant. This small overestimate of the SAPS II score was similar to the same age nonpregnant female controls and to the published data on APACHE II in the same population at university hospitals.❖

Problems with conventional medicine in patients seeing unconventional practitioners

W. Michael Wilson, MD, Fitchburg

Background
Patients are influenced by many factors in choosing a health care provider. A survey was conducted to establish the problems with conventional medicine that may influence patients to see an unconventional practitioner.

Methods
Three groups of patients were studied. Group One was patients attending a family practice clinic. Group Two was patients attending a chiropractor. Group Three was patients attending two "holistic" clinics. The practitioners at these clinics were using mainly naturopathy and homeopathy. Patients were asked to complete a survey while waiting to see the practitioner. Two hundred three surveys (response rate 84%) were completed in a 100% convenience sample of patients attending each practice in a one-week period.

Results
Patients attending unconventional practitioners reported significantly more problems with conventional medicine than did those patients attending a family physician. The patients of unconventional practitioners perceived that lack of communication by conventional doctors was the major problem. Compared with patients of family physicians, patients of unconventional practitioners were much more likely to have perceived that conventional doctors did not understand their concerns, prescribed too many medications, and did not spend enough time with them. They perceived that conventional medicine does not treat the whole person. There was agreement between all groups that doctors seem confident that their diagnoses are correct and confident that their treatment will work.

Conclusions
Problems in the doctor-patient relationship may have influenced patients to see unconventional practitioners. By addressing the problems identified in this study, doctors can work to improve the relationship, and thus, improve patient satisfaction.❖

In an instant a stroke can change your life forever

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Prevalence of anemia in a typical urban African American population

Loren A. Leshan, MD, Milwaukee

Objective: To determine the prevalence of anemia in a typical urban African American population.

Design: Cross sectional screening study.

Setting: School-based clinic in an urban, medically underserved, predominantly African American high school in the Midwest.

Patients: African American adolescents attending health far or clinic at high school.

Measures: Hemoglobin levels.

Main Results: Mean hemoglobin for girls was 11.5 and for boys 12.9.

Conclusions: A high incidence of anemia was found in this population of inner city African American high school students.❖

A longitudinal experience in fiberoptic flexible sigmoidoscopy training in a family practice residency program

John R. Brill, MD, and Dennis J. Baumgardner, MD, Milwaukee

Purpose

Numerous methods of screening for colorectal cancer (CRC), the second leading cause of cancer death in the US, have been advocated, among them fiberoptic flexible sigmoidoscopy (FFS). For FFS to be accessible, primary care physicians must be trained in its use; this training is best done during residency. Previous studies have looked at the training of family practice (FP) residents by gastroenterologists in block rotations. We present data from exams performed by residents supervised by FP faculty on a longitudinal basis in the Family Practice Clinic (FPC).

Methods

From 1986 until the present, data from all FFS done at the St. Luke's Family Practice Residency Program have been recorded on a specially designed form. This cumulative data has been computerized and analyzed. The primary endpoint examined is number of exams needed to achieve proficiency, as measured by unassisted depth of intubation. Patient factors that may affect exam performance, sigmoidoscopic findings, and complications are also analyzed.

Results

A total of 315 exams performed by 65 residents and faculty were analyzed. Regression analysis reveals a modest correlation between increasing numbers of exams and increased depth of independent intubation; patient factors such as female gender, prior abdominal surgery, and diminished preparation quality are significantly negatively correlated. A relatively low (11.1%) rate of polyps was detected. Only one minor complication occurred.

Conclusions

Training of FP residents in FFS can be done safely and effectively by FP faculty in their own clinic setting. The number of exams needed to achieve proficiency appears to be 15-20. Difficult exams can be predicted from the patient's history.

Youth substance use: A comparison of data from two rural Wisconsin communities and the development of community interventions

Marma Jean McIntee, MS, Madison

Purpose

(1) To identify behaviors that place the health and safety of adolescents at risk.
(2) To develop community awareness of adolescent health issues.
(3) To build a foundation for school and community prevention and education programs.
(4) To provide baseline data to measure effectiveness of interventions.

Methods

The Youth Risk Behavior Survey instrument was distributed to grades 4-12 in two rural Wisconsin schools. Descriptive data (N, percent) were analyzed using SPSS and compared with Wisconsin and US data.

Results

Findings from the Youth Risk Behavior Survey identified several areas of high risk for adolescents in the communities surveyed. This presentation will concentrate on substance use, especially alcohol and tobacco use, which was higher than Wisconsin and US data for the same age groups. In addition to a brief introduction of the findings, the presentation will provide information about how one community is organizing to build on community, family, and adolescent strengths and reduce risk.❖

The relationship between fatigue and depression in primary care

Arthur J. Hartz, MD, PhD, Evelyn M. Kuhn, PhD, Richard London, MD, Milwaukee

Depression is commonly considered to be an explanation for fatigue. This study examines how depression affects the treatment and course of fatigue.

Subjects were selected for this study from 1,140 patients in an ambulatory practice who completed a screening questionnaire on fatigue and depression. Detailed questionnaire and medical record information was available on 159 of these subjects, and 6-month follow-up questionnaire information was available from 139 subjects. Determination of fatigue was based on the Rand Vitality Index and determination of depression was based on the Zung depression score.

Twenty percent of the patients who completed the screening questionnaire said that fatigue often interfered with the quality of their life and 14% met the criteria for severe fatigue. Of the 72 patients with fatigue of more than 6 months who had complete follow-up information 28 (39%) had depression. The presence of depression greatly influenced the treatment (71% had medication or counseling compared to 39% of those without depression) and the number of annual visits for psychological counseling (1.2 per year with depression vs .4 per year without depression). It had no influence, however, on whether the patient thought that the physician had been helpful in improving the fatigue (30%), the number of medical visits a year (nine), and the percentage of patients who substantially improved within six months of follow-up (33%). The correlation between change in depression and change in fatigue score from baseline to follow-up was very low (.13).

These results suggest that fatigue is a common, important, and difficult-to-manage problem, independent of its association with depression.❖

Diabetic ketosis/ketoacidosis (KDA) in a community hospital: Outcome and cost differences between patients admitted to primary care MDs (PC) versus endocrinologists (ENDO)

Glenda Clay, RDCDE, Kathy Vande Hei, RNCDE, Mike Tesmer, MS, CC Leigh, MD, Scott Magee, MD, Appleton

NATIONALLY, most individuals with DM and most episodes of DKA are managed by PC. Since we practice in an area increasingly dominated by HMOs which overtly or covertly limit use of subspecialists and since care rendered by subspecialists is frequently cited as more expensive and less cost effective than care by PC, we questioned whether cost ($) or outcome (Length of Stay = LOS) of DKA episodes at our institution differed between PC and ENDO. Data from all admissions to St. Elizabeth's Hospital, Appleton, with a primary diagnosis of DKA (ICD 250.10-250.13) between Jan 1, 1991 and Dec 31, 1994, were obtained via the hospital's medical records computer system. Since prior studies have shown that age strongly influences DKA outcome and the age distribution of PC and ENDO patients was markedly different, a subgroup analysis of age matched patients was also performed (table).

The ENDO patients were less hyperglycemic but more acidotic across all groups. Preliminary analysis suggests that these differences should not contribute to a difference in LOS or Cost (see correlation coefficients). LOS and Cost were consistently lower but intensity of resource use ($/day) consistently higher for ENDO vs PC patients.

Conclusions: Care of DKA pts by ENDO is more resource intensive but yields a better outcome (LOS reduced = 20-40%) and lower overall cost ($ reduced = 11-30%). The development of treatment guidelines which mimic the ENDO treatment parameters and the application of such guidelines to all patients hospitalized with DKA could reduce average LOS and cost for this common condition.❖

Group	All DKA Pts		DKA Pts <20yo		DKA Pts >20yo <49yo		Correl Coeff
	PC	ENDO	PC	ENDO	PC	ENDO	
# of pts	51	18	20	5	24	13	
Age	29.1	26.8	13.4	15.0	32.0	31.3	Cost & Age 0.37
Glucose	568	489	456	405	617	521	Cost & Gluc = 0.22
pH	7.24	7.17	7.25	7.03	7.24	7.20	Cost & pH = *0.14
LOS	4.3	2.5	3.8	3.0	3.3	2.3	Cost & LOS = 0.85
$	4564	3192	2626	2393	4220	3500	
$/day	1193	1430	922	998	1420	1596	* all data = means

The relationship of chronic fatigue and the hemodynamic response to stress

Clare E. Guse, MS, and Arthur J. Hartz, MD, PhD, Milwaukee

Objective
Large amounts of catecholamine released in response to stress may lead to fatigue. This suggests that hot reactors (persons with large hemodynamic response to stress under laboratory conditions) may be more fatigued in their daily life.

Design
Subjects provided information on their demographic characteristics, usual level of fatigue at three time points during the day, and lifestyle information that may be associated with energy level. The hemodynamic response to stress was determined by taking blood pressure (BP) measurements every minute during 5 minutes of relaxation and 10 minutes of video game playing. The measure of hemodynamic response was the maximum change in BP from rest to stress, adjusted for baseline BP values and gender. The association between fatigue at a given time period and the hemodynamic responses was tested using the Pearson correlation.

Subjects
Sixty-two subjects (68% women) ages 17 to 62 (mean=37.3) were recruited from the Medical College of Wisconsin and Family Health Plan. Two subjects on beta-blockers were excluded.

Results
Neither BP response, demographic factors or lifestyle factors were associated with morning or daytime fatigue. Evening fatigue was associated with changes in both systolic BP (P=.05) and mean BP (P=.06).

Conclusions
These results suggest that the degree of hemodynamic responsiveness to stress may be associated with the development of fatigue at the end of the day.❖

Blastomycosis in dogs II: A 15-year study in an extremely highly endemic area near Eagle River, Wis

Dennis J. Baumgardner, MD, Nick W. Turkal, MD, and Daniel P. Paretsky, DVM, Milwaukee

Purpose
To follow up a study which suggested a bimodal age distribution for dogs with blastomycosis in North Central Wisconsin, and identified an area of very high endemnicity.

Methods: In June, 1994 a mail survey was sent to 216 owners of properties known to exist within the highly endemic area for blastomycosis surrounding the confluence of the Wisconsin and Eagle Rivers in Vilas County, Wisconsin. Owners were asked to list all dogs kept at that property since 1980, to detail their dogs' demographics and longevity, and the occurrence of veterinarian-diagnosed blastomycosis. Features of dogs with and without disease were compared using Epi Info software.

Results
Seventy-one (33%) of the surveys were returned, and 53 of these properties had housed one or more dogs during this time (87 total dogs). Seventeen (20%) of these 87 dogs had a history of blastomycosis, and 28% of the 53 properties had housed one or more dogs with blastomycosis. All 17 dogs with blastomycosis lived on properties adjacent to, or within 100 feet, of the shoreline, compared to 76% of dogs without disease (P=0.03). Males and purebred dogs were not overrepresented in cases. Seventy-one percent of blastomycosis cases were three years of age or less at diagnosis; 88% had been at that property three years or less until diagnosis, and 59% less than one year. (The average length of time on the property for dogs without apparent blastomycosis was 5.7 years, and age at death, 12.4 years.)

Conclusions
Among dogs, young age and recent exposure to a highly endemic parcel are risk factors for blastomycosis, and raise speculation regarding the existence of acquired natural immunity to this disease.❖

Project: TREAT

Michael Fleming, MD, MPH, and Kristen Barry, PhD, Madison

Purpose
The goal of this trial was to test the effect of brief physician advice on alcohol-related behaviors and health status of problem drinkers under the age of 65.

Sample and method
Subjects were selected from the practices of 69 primary care physicians in 17 practices located in southcentral Wisconsin. The trial was focused on the treatment of adult problem drinkers, defined as men who drank 15 or more drinks/week, women who drank 12 or more drinks/week, or men or women who binge drank. A total of 17,695 patients completed the initial Health Screening Survey. Fourteen percent (n=2,477) of the patients screened positive and received a further diagnostic interview by the research staff to determine eligibility for the study. Each physician was randomly assigned an experimental and a control group. There were 307 patients who received the intervention and 382 assigned to the control group.

The intervention protocol included a brief intensive counseling session, a self-help manual, an agreement to change drinking habits, a 1-month follow-up visit, and two follow-up phone calls. Fourteen outcome variables were selected based on the findings of completed clinical trials. These variables include:

- number of weeks of sobriety;
- number of episodes of binge drinking;
- alcohol use in the 7 days prior to the 6- and 12-month follow-up interviews;
- days of hospitalization;
- sick days;
- injuries and accidents;
- emergency room visits;
- legal events;
- global perception of health;
- number of outpatient visits;
- number of prescriptions;
- self-reported health status;
- family relationships; and
- number of chronic illness days.

The outcome variables were assessed by a self-report telephone interview at 6 and 12 months, a telephone interview with a family member at 12 months, and a review of medical records.

Results
The experimental group drank significantly less in the seven days before the 6- and 12-month follow-ups than the control group. At baseline, the experimental and control groups drank an average of 20 and 19 drinks/week, respectively. At the 6-month followup there was a significant difference between the experimental and control groups in alcohol consumption in the week before the interview (experimental mean=11; control mean=15; p=.0001). At 12-month follow-up the results remained consistent (experimental mean=12; control mean=16; p=.0001).

Conclusion
This was the first large-scale, randomized clinical trial conducted in the United States to test the effect of brief physician advice with problem drinkers in a non-academic primary care setting. Brief advice is an effective method for change in problem drinkers in primary care settings.❖

Additional findings about the temporal clustering of appendicitis

Andrew V. Pasternak, MD, and Jonathan L. Temte, MD, PhD, Madison

Purpose
Appendicitis is a common surgical emergency often first evaluated by primary care physicians. Several previous reports have indicated that cases are not randomly distributed through time; rather appendicitis may be seasonal and is possibly clustered in time. Such temporal behavior may indicate a causative role of infectious agents.

Methods
We evaluated 719 sequential appendectomies performed over a 4-year period at our medical center to determine the demographics and timing patterns of tissue-verified appendicitis. The time of presentation to the hospital and the time of anesthetic induction were recorded for each case along with patient age and sex, and tissue diagnosis from the surgical specimen. We used Edwards' method to test for cyclic trends. The distribution of days-between-cases was compared to a random (Poisson) distribution to test for possible clustering of cases.

Results
Appendicitis was more common in younger patients and in males. Delay in definitive treatment increased with age and resulted in higher grade of appendicitis. Significant cyclic trends were noted for times of presentation and anesthetic induction. For example, presentation of cases demonstrated significant 24-hour ($P<0.001$), weekly ($P<0.025$), and semi-annual ($P<0.025$) cycles. Moreover, appendicitis in the community displayed significant clustering behavior ($P<0.0001$).

Conclusions
Cases of appendicitis do not occur randomly in time, but are clustered. In addition, the time of presentation has circadian, weekly, and semi-annual periodicity. These temporal characteristics strongly suggest an etiological role for an infectious agent and warrant further investigation.❖

Infectious asthma and chlamydia pneumoniae IgA antibody

David L. Hahn, MD, and Roberta McDonald, Madison

Background
Studies associating Chlamydia pneumoniae-specific polyvalent (mixture of IgM, IgG and IgA) antibody with adult asthmatic bronchitis and asthma have not clearly distinguished prior exposure from current chronic infection. Since C. pneumoniae-specific IgA antibody may be a marker for chronic infection, we measured IgA antibody in adult reactive airway disease classified as infectious or noninfectious in origin.

Methods
104 middle class adult outpatients (mean age 42.4 years) with acute asthmatic bronchitis or chronic asthma were studied in a community-based primary care (family practice) clinic. Asthmatic syndromes were classified as infectious if initial reported symptoms began after an acute respiratory illness (usually diagnosed as bronchitis, pneumonia or an influenza-like illness), or as noninfectious (atopic, exercise-induced or occupational asthma). C. pneumoniae-specific IgG and IgA antibody were then measured.

Results
68/104 (65.4%) patients were classified as infectious. IgA seroreactivity (titer of 1:16 or greater) was 62% in infectious asthma, versus 22% in noninfectious asthma ($P=.0002$). Regression analysis controlling for age, sex, smoking, and symptom duration showed a significant quantitative association between IgA titer magnitude and infectious asthma ($P=.0024$). Similar, but weaker, associations were present for IgG seroreactivity ($P=.04$) and titer magnitude ($P=.029$).

Conclusions
Infectious asthma is associated with serologic evidence for chronic C. pneumoniae infection.❖

A survey of customers and the products purchased at two health food stores

B. Clair Eliason, MD, Janine Kruger, David Mark, MD, MPH, Dale Rasmann, MS, RD, Milwaukee

Nutritional or dietary supplements sold in health food stores and other locations have grown to a multi-billion dollar industry. These supplements include vitamins, minerals, herbal products, tissue extracts, amino acids, and other chemicals. Unless a specific drug effect is claimed, the FDA minimally regulates this industry and neither safety nor efficacy studies are required.

About 50% of the adult population have been shown to take a dietary supplement in a given year. Most are vitamins and minerals taken at safe doses. However, many supplements are taken at megadoses, in unusual combinations and are products that are untested in humans. Some have been shown to be unsafe but remain on the market. We did a survey of products taken and the demographics of the populations using health food stores. We obtained permission from two health food stores to do a survey of their customers. One hundred and thirty-six customers of 194 (70%) participated in the study.

The respondents were mainly female (75.5%), white (94.2%), middle-aged (51.5% were 40-60 years of age), and had attended one or more years of college (70.6%). The 136 customers surveyed took 805 supplements. The average number of products consumed was 5.9/customer with a range of 25 to 1. Herbal products were the most frequently consumed product followed by multivitamins/minerals, natural food supplements, vitamin E megadose, B vitamins, vitamin C megadose, and 20 other product groups made up the remainder. Customers surveyed took most products to prevent a problem (84.3%) and only 15.7% to treat a problem. A variety of benefits were perceived.

Most of the respondents had medical insurance (95.6%) and a regular physician (85.3%), but only 6.1% of the products taken had been recommended by their physician. About half of them were also taking prescription medications.

Vitamins and minerals in safe doses constituted 293 (36.4%) of the products. The other products which have not generally been tested for safety and efficacy were herbal products 217 (27.0%), megadose vitamins 101 (12.5%), single chemicals 94 (11.7%), supplement combinations and other products 57 (7.0%), protein/amino acid preparations 31 (3.9%), and tissue and glandular extract 12 (1.5%).

Several products were identified in the survey that have caused toxicity and have been reported as potentially unsafe. These include herb mixtures of Ma Huang and Kola-Nut, thyroid tissue extract, the herb Lobelia, Chromium picolinate, Kombucha mushroom tea, and the herb Yohimbe.

Physicians should become more knowledgeable about these products and have a dialogue with their patients asking specific questions about herbal products.❖

Precounseling in a family practice residency program

Brian K. Wallace, MD, and Alan S. Wolkenstein, MSW, Milwaukee

The effective management of mental illness, adjustment disorders of normative family and individual life-cycle events, and coping with illness (effects of quality of life) are fundamental aspects of primary care. Emotional problems are more prevalent than otitis media, coronary artery disease, hypertension, and diabetes. It follows that residency training should place a premium on teaching residents in the proper evaluation and management of such disorders. On the contrary, behavioral sciences training is often limited. Residents generally receive little effective experience in counseling, mental health referral, or management of coping disorders. Residents should not be expected to make such mental health interventions without the same role modeling, supervision, and feedback on their performance that they receive in all other aspects of their training.

The St Luke's Residency Program recognizes the relevance of such training. It has developed a "precounseling" program which has

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been integrated into its curriculum. It has been specifically designed to replicate the practice patterns of family physicians within the context of resident education. It provides role modeling of therapeutic techniques, supervision and feedback on resident performance, and maintains the patient-doctor relationship while assessing patient resources, coping skills, and needs. It is also helpful in assessing the resident's attitudes, beliefs and values toward mental health and mental health services. Equally important, it provides a mechanism to prepare a patient for possible mental health referral. It has been demonstrated that effective preparation for mental health referral is an important factor in compliance.

Precounseling's value in improving compliance with recommended medical therapy and mental health referral is currently being evaluated by the collaborators and will be presented. Residents' and patients' attitudes and observations regarding precounseling will also be presented.❖

Quality of life in the healthy elderly; patient and physician perspectives

Nick W. Turkal, MD, Alan S. Wolkenstein, MSW, Dennis J. Butler, PhD, Milwaukee

Purpose

A primary goal of medical practice is to improve the patient's quality of life. There is little question about medicine's dedication to enhancing quality of life, but there are many questions about the definition of quality of life and the impact of medical care upon it. The intent of this study was to compare the beliefs held by healthy elderly patients and their physicians around quality of life issues.

Methods

Focus groups and a survey tool of healthy elderly provided feedback regarding their views on quality of life issues. Faculty and resident family physicians were surveyed regarding their beliefs on quality of life issues for the healthy elderly.

Results

This sample of healthy elderly individuals defined quality of life as (1) the outer world and its people (their total environment plus their functional status), (2) the inner world of the self (degree of self esteem and desire for independence), and (3) coping with loss (acceleration of losses and declining resources). They also identified certain physician behaviors which they believed would enhance their quality of life. Physicians reported that they believed the following issues to be the most important to their patients: productivity, self determination, social involvement, purpose, coping skills, and absence of pain.

Conclusion

Beliefs around quality of life issues for the healthy elderly population differ for each individual, but some underlying themes were repeatedly identified as important. However, many physician definitions of quality of life were not derived from patients themselves and therefore underestimated the importance of this to the elderly. This tended to contribute to physicians not properly incorporating this concept into patient care. There is an underutilized opportunity for residency programs to educate future family physicians about the importance of understanding individual patients' definitions of quality of life. Additional studies of larger populations of healthy elderly and their physicians would help to clarify these needs.❖

Medical miracles start with research

American Heart Association℠
Fighting Heart Disease and Stroke

Asymptomatic bacturia in pregnancy in an urban family practice residency program

Dennis J. Baumgardner, MD, Betty Stangl, William Fleming, MD and Avis Christopherson, LPN, Milwaukee

Purpose

Up to 12% of pregnant patients may have asymptomatic bacturia. Staphylococcus saprophyticus, a coagulase-negative staphylococcus, has been reported to cause asymptomatic bacturia. Our purpose was to determine the prevalence of asymptomatic bacturia in our pregnant population, and whether Staph saprophyticus is a frequent etiologic agent.

Methods

Prospectively enrolled and retrospectively analyzed, by chart review, were 218 consecutive women at our urban family practice center who received their initial, routine prenatal pelvic examination with bladder catheterization for urine culture, and formal symptom assessment. These subjects presented between July 15, 1991, and June 22, 1993, and also received tests for cervical Chlamydia trachomatis and Neisseria gonorrhoeae. Omitted were two patients who had received antibiotics within 2 weeks of presentation, and seven patients with unrepeated contaminated urine specimens. Dichotomous variables were compared between the groups with and without bacturia (10,000 or more colonies/ml of known or suspected pathogens) using Fisher's Exact Test for two-by-two tables with cells less than five, and Chi-square Test with Yates' correction for all others.

Results

Twenty of 218 patients (9.2%) had significant bacturia (E coli [8 patients], group B streptococcus [5], Klebsiella [2], enterococcus [2], Citrobacter [1], and coagulase-negative staphylococcus [1]). Bacturia patients were of similar age and marital status, and no more likely than patients with negative cultures to have experienced dysuria (2/20; p>0.5), frequency (8/20; p=0.1), urgency (4/20; p=0.1), low back pain (4/20; p=0.3), fever (1/20; p=0.4), or none of these symptoms (10/20; p=0.3). The single patient with coagulase-negative staphylococcus had experienced dysuria, frequency and urgency. Of the 12 non-bacturic patients with dysuria, two had cervical Chlamydia trachomatis; none had Neisseria gonorrhoeae.

Conclusions

The prevalence of bacturia at first routine obstetrical examination at our urban family practice residency was 9.2%. The majority of positive urine cultures were caused by gram negative enteric pathogens or group B streptococcus.❖

Family practice ambulatory morning report: a resident-initiated educational forum

Jean MK Slane, MD, and Denis J. Baumgardner, MD, Milwaukee

Pre-testing of residents at our urban family practice program revealed that the majority felt they had insufficient teaching and case presentations opportunities as a resident. They also rated traditional inpatient hospital morning reports as only somewhat useful in both overall learning and patient care.

Residents initiated a weekly family practice ambulatory morning report as an educational forum providing opportunities to teach and present cases and to learn ambulatory clinical decision making. Residents self-selected cases for presentation. Participation was voluntary and 100% agreed to present a case.

The content of the cases was analyzed and compared to previously published analysis of an internal medicine ambulatory case conference at a similar hospital in Milwaukee. Not unexpectedly, the family practice forum covered a broader range of primary care problems, including cases in OB, gynecology, preventive care and terminal care.

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In addition, a significant number of cases (34%) addressed issues of medical ethics, professional conduct, and social responsibility.

The cases presented fairly represented the types of patients seen in family practice. The ages ranged from birth to 92; 75% were female; psychosocial issues were central management issues in over 50% of the cases. The average case presented depicted clinical decision making over a 6-month period of time.

Attendance at the conference was voluntary. The average number of attendees was 17. These included family practice and transitional year residents, medical and PA students, faculty, visiting consultants, advance practice nurses and staff nurses. Residents who attended tended to be those who on pretesting evinced an interest in FP research or academic medicine.

Resident attendees ranked the conference as highly useful; it compared favorably to one-on-one faculty teaching in terms of usefulness to overall learning. It was rated much more useful than internal medicine conferences including inpatient morning report in terms of usefulness to specific patient management.

We conclude that a weekly family practice morning report, initiated and sustained by residents, can be highly useful to academically inclined FP residents.❖

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Behavioral risk factors of cardiovascular disease: a study of the citizens of Franklin, Wisconsin

Carol Sibilski, RN, BSN, and William Wucherer, RN, BSN, Franklin

INFORMATION ABOUT risk factors for cardiovascular disease is often available at the national and state level,[1] but not as readily available at the local level. Assessment of the disease burden and potential for prevention is a core function of public health. Accordingly, the City of Franklin Health Department conducted a telephone survey to determine the self-reported incidence of cardiovascular disease and behavioral risk factors among the citizens in the City of Franklin and to compare their responses to the cardiovascular objectives in *Healthier People in Wisconsin - A Public Health Agenda for the Year 2000.*[2]

Background

Franklin, Wis, population 21,855, is a fast-growing middle income community located in Milwaukee County. In 1993, cardiovascular disease was selected as a public health priority, as part of a citizens needs assessment.[3] In 1993, 47 (39%) of the 118 deaths in Franklin were attributed to coronary heart disease. Hospitalization statistics showed there were 321 inpatient discharges for cardiovascular/coronary heart disease, representing 13% of all inpatient discharges.[4]

Methods

The City of Franklin Health Department developed and administered a telephone survey to a random sample of City of Franklin residents. The survey was comprised of 21 questions, and was developed so that it could be administered in no more than 5 minutes. The surveys, performed by public health nurses, were conducted during an 8-week period, with calls made during the early evening hours (4-7 pm) to residents over 18 years of age. Data were analyzed using Epi Info 6.02, a database and statistical package.[5]

Results

The Health Department obtained responses from 409 adults, which represented a 60% response rate. Overall, 28% of those surveyed reported that they had one or more forms of cardiovascular disease. Of all respondents, 22% reported hypertension, the most commonly reported form of cardiovascular disease. The self-reported incidence of stroke was reported at 2%, while the incidence of other forms of heart disease was reported at 11%.

High blood pressure, a major risk factor for stroke was reported by 22% of survey respondents, making this the highest ranking form of cardiovascular disease in Franklin. One way to reduce this risk is through the awareness that can be gained through regular blood pressure screening. It was found that 97% of the sample had their blood pressure taken in the past two years. The objective of *Healthier People* for blood pressure screening is 90% of the population by the year 2000. From the survey results, it appears that this goal has been achieved for the sample respondents. While this large percentage of the sample had their blood pressure taken in the past 2 years, 98% could recall whether the reading was high or normal, but only 48% of these respondents could report the blood pressure "numbers."

Elevated blood cholesterol is another cardiovascular risk factor. Of those surveyed, 75% reported hav-

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Sibilski is a public health nurse and Mr Wucherer is health services administrator with the City of Franklin Health Department, 9229 West Loomis Road, Franklin, Wisconsin, 53132. This study was made possible through funds provided by the Federal Prevention Block Grant. Copyright 1995 State Medical Society of Wisconsin.

Continued from preceding page
ing their blood cholesterol checked within the past 5 years, which falls slightly below the objective of 80% in *Healthier People*. Of those who reported having their cholesterol level tested, 70% reported normal levels and 25% reported elevated levels, with the remaining 5% unsure of the level. Nationally, 25% of the population reports having elevated cholesterol levels.

In *Healthier People*, 45% of adults exercised regularly in 1988. The greatest effect of physical inactivity is that it can contribute to overeating, weight gain, and elevated blood cholesterol which are risk factors for heart disease.[6] While 51% reported participation in an exercise program for 15-30 minutes at least three times a week, a level considered to be moderately intense, this level of participation is below the 75% objective in *Healthier People*.

No risk factor has had a greater effect on heart disease than smoking. Estimates have placed tobacco usage as a contributing factor in 17%-30% of cardiovascular deaths, making this of great concern to public health.[6]. Of those surveyed in Franklin, 19% reported that they smoke cigarettes, below the Wisconsin rate of 23%. However, the objective for adults in *Healthier People* to reduce this level to 15% or less.

Overweight is a risk factor for cardiovascular disease, hypertension, and diabetes. Overweight, as measured on the survey, was derived from self-reported height and weight. From this information, body mass index (BMI) was calculated. BMI is a ratio of weight to height (kg/m^2).[7] According to these definitions, 29% of respondents were overweight, compared with the 30% reported to be overweight in Wisconsin.

Emotional stress has been considered a contributing risk factor for cardiovascular disease and may contribute to established risk factors. Findings indicated that 32% experienced a lot of stress, 48% experienced moderate stress, and 20% reported having little or no stress. Respondents were also asked to relate how stress affected their health during the past year, with 15% attributed a great effect, 36% with some effect, and 49% with no effect at all.

Comparison of health behaviors of City of Franklin, Behavioral Risk Factor Survey, and Healthier People in Wisconsin Year 2000 Goals

Risk behavior	Franklin (1994)	Behavioral risk factor survey (1994)	Healthier People Year 2000 Goal
Blood pressure checked (within past 2 years)	97%	93%*	90%
Serum cholesterol level checked (within 5 years)	75%	64%*	80%
Physical Activity	51%	45%	75%
Smoking	19%	23%	15%
Overweight (BMI)	29%	30%	25%
Emotional Stress			
Moderate	32%	---	---
Alot	48%	---	---

* 1993 survey results.

Diabetes mellitus and family history of cardiovascular disease are two other risk factors for cardiovascular disease for which information was gathered. A total of 3% of survey respondents in Franklin and in the Behavior Risk Factor Survey reported being told by a doctor that they had diabetes.

Discussion

Prevention of the onset of heart disease and reversibility of its effects can be achieved through modification of risk factors such as elevated blood pressure, high serum cholesterol levels, cigarette smoking, and physical inactivity. The City of Franklin Health Department decided to obtain more specific data from citizens about cardiovascular disease, the leading cause of death among its citizens.

With the local survey results the public health department now is in a better position to determine the allocation of resources needed to work toward progress of the stated objectives. The information will be shared with members of the community as an encouragement to actively participate in positive health behaviors, such as reducing weight, and increasing physical activity. The local data gathered in this effort may be able to demonstrate to the citizens of Franklin that the risk factors studied contribute to cardiovascular disease in their community.

Acknowledgements

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An assessment of prehospital provider needs in Wisconsin

Dean Stueland, MD, Marshfield, Mary Jean Patzner, RN, Cuba City, and Robert Rauch, Marshfield

The Emergency Medical Systems Advisory Board assessed via questionnaire the needs of Wisconsin prehospital providers. Overall, 323 out of 453 (71.3%) of the services responded to the query. Intermediate and paramedic services were more likely to respond than those prehospital providers offering basic services. Of the respondents, however, 235 (72.8%) identified their service as basic. In addition to providing information about service characteristics, each responding provider also rated its perceived needs. All prehospital providers, regardless of service level, ranked "lack of medical director" as the issue of greatest concern. Continuing on, intermediate and basic providers rated difficulty in recruiting new staff as the second greatest need. Paramedic providers, however, identified dispatching as their second greatest need. Rural providers rated difficulty in recruiting new staff and difficulty in collecting ambulance fees as their second and third greatest needs, respectively. Urban providers, meanwhile, indicated difficulty in collecting ambulance fees and access to local training as the second and third top needs, respectively. With the proposed new curriculum for basic EMT services, the needs for local medical direction will be even greater. *Wis Med J.1995;94(12):689-692.*

The present pressures on the overall medical care system influence the prehospital care system as well as hospital-based providers. Prehospital providers share (along with other health care providers) pressures regarding accountability, costs, mandates, and efficiency. At the same time, there are advances occurring in the understanding and techniques in the provision of prehospital care. Furthermore, there are increased public expectations of prehospital care. In Wisconsin, much of the prehospital care is provided by volunteers and the system may be perceived as unstructured.

To better understand the pressures facing prehospital providers, the Emergency Medical Services Advisory Board of the State of Wisconsin developed and conducted a survey of Emergency Medical Services (EMS) providers.

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Methods

After the EMS board developed the survey, it was sent by the Section of Emergency Services of the Department of Health and Social Services to all licensed prehospital providers, using the provider address on file with the state. The respondent was presumed to be the person who usually handles correspondence.

Prehospital providers were asked to characterize themselves by level of service (basic, intermediate, or paramedic) and indicate type of service area (densely urban, urban, suburban, semi-rural, rural-remote).

In addition, the respondent was asked to rate several issues on a scale from one ("little concern") to five ("critical concern"). The respondent was also asked to describe characteristics of the service and indicate areas needing continuing education.

This article focuses on the needs that the respondents identified.

Results

Table 1 segregates the respondents by level of service. Overall, over 70% of potential respondents did return the survey. More than 70% of those

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responding offered basic services although intermediate and paramedic prehospital providers did have a higher response rate.

To validate the level of service and the service area, these parameters were compared by number of ambulance runs, number of equipped ambulances, and stations. In each of these parameters, the progression from basic to paramedic and rural to urban verified an increase in activity suggesting that these self-reported categorizations were reasonable.

Table 2 displays the 14 areas of needs assessment in decreasing order. The most critical areas relate to medical direction and staff recruitment. The least critical areas identified were interfacility transfers, quality assurance and availability of helicopter support.

To better understand the differences between levels of service, the mean responses, by service level, are shown in Table 3, with a test of significance. Variables with significant difference between levels of service include medical direction, staff recruiting, and interfacility transfers. The need for medical direction was rated as more than 4 by paramedic and intermediate providers, but basic providers ranked it 3.5 (still listing it as their greatest need).

Basic and intermediate providers identified problems with retaining human resources, giving that need a rank greater than 2 on the survey. Retaining staff was ranked only 1.6 by paramedic providers. Transfers were considered to be more of a problem by paramedic services than intermediate or basic services.

To better evaluate the effect of service area on needs, the two urban program types were compared with the two rural program types (Table 4). Significant differences between service area responses were noted in issues related to medical direction, recruiting, retaining, political boundaries, system abuse, and interfacility transfer. Urban prehospital providers rated a concern for "lack of medical director" higher than did rural services. But rural providers considered both "recruiting" and "retaining" as higher needs than did urban providers. Urban providers viewed political boundaries, EMS system abuse and interfacility transfer as their gravest problems.

Table 1- Response rate to the Wisconsin EMS board survey by provider category

Category	Number responding	Potential respondents	Response rate
Basic	235	347	67.7%
Intermediate	52	63	82.5%
Paramedic	36	43	83.7%
Total	323	453	71.3%

Chi-square = 9.3010 p = <.0096

Table 2 - Ratings of needs by 323 respondents to the Wisconsin EMS Board Survey

Subject Area	Number Responding	Median	Mean
1. Lack of a Medical Director	304	4	3.64
2. Difficulty in recruiting new staff	223	3	3.30
3. Difficulty in collecting ambulance fees	292	3	2.85
4. Dispatch and communications	308	3	2.62
5. Training in your area	322	3	2.51
6. Difficulties in retaining EMTs in your organization	319	2	2.36
7. Mandatory refresher training for your service	320	2	2.24
8. Political boundaries of your service	319	2	2.20
9. EMS system abuse	321	2	2.17
10. Funding assistance program	315	2	2.12
11. Hospital support for EMS Services	316	2	2.03
12. Availability of helicopter service	306	2	1.94
13. Quality Assurance Program	277	2	1.93
14. Critical Care and interfacility transfers	304	1	1.83

Discussion

The needs assessment clearly demonstrates that medical direction is considered to be a major need at all levels of service and in all service area types. With the implementation of a new basic curriculum, the need for local medical direction will be amplified.[1] It is interesting to note that paramedics saw the concern for a lack of medical director as more of an issue than did basic providers.

Table 3 - Response by service level of 323 respondents of the Wisconsin EMS Board Survey

Subject Area	Basic N	Basic Mean	Intermediate N	Intermediate Mean	Paramedic N	Paramedic Mean	F Ratio	Probability Level
1. Lack of a Medical Director	222	3.47	48	4.04	34	4.18	6.96	.0011
2. Difficulty in recruiting new staff	183	3.37	27	3.19	13	2.62	2.45	.0887
3. Difficulty in collecting ambulance fees	214	2.86	45	2.78	33	2.82	0.14	.8662
4. Dispatch and communications	224	2.61	49	2.51	35	2.86	0.77	.4629
5. Training in your area	234	2.60	52	2.31	36	2.28	2.37	.0954
6. Difficulties in retaining EMTs in your organization	232	2.51	51	2.20	36	1.58	12.42	<.0001
7. Mandatory refresher training for your service	233	2.28	51	2.04	36	2.25	0.81	.4440
8. Political boundaries of your service	233	2.11	52	2.54	34	2.29	2.52	.0823
9. EMS system abuse	233	2.16	52	2.23	36	2.36	0.86	.4243
10. Funding assistance program	228	2.10	51	2.02	36	2.40	1.11	.3296
11. Hospital support for EMS Services	230	2.09	50	1.74	36	2.08	1.79	.1693
12. Availability of helicopter service	223	2.00	50	1.76	33	1.76	1.53	.2176
13. Quality Assurance Program	190	1.92	51	1.96	36	1.94	0.05	.9489
14. Critical Care and interfacility transfers	218	1.82	50	1.56	36	2.25	4.25	.0152

Table 4 - Service area by responses for 232 respondents to EMS Board Survey

Subject Area	Urban N	Urban Mean	Rural N	Rural Mean	T Value	P Value
1. Lack of a Medical Director	31	4.23	219	3.59	2.51	.0120
2. Difficulty in recruiting new staff	12	2.50	179	3.43	2.67	.0084
3. Difficulty in collecting ambulance fees	30	2.97	212	2.86	0.53	.5927
4. Dispatch and communications	29	2.31	226	2.73	1.62	.1052
5. Training in your area	32	2.69	235	2.56	0.62	.5355
6. Difficulties in retaining EMTs in your organization	32	1.69	234	2.53	4.26	<.0001
7. Mandatory refresher training for your service	32	2.44	234	2.17	1.15	.2500
8. Political boundaries of your service	30	2.63	234	2.13	2.04	.0413
9. EMS system abuse	32	2.53	234	2.09	2.57	.0100
10. Funding assistance program	32	2.34	230	2.02	1.47	.1411
11. Hospital support for EMS Services	32	2.38	229	1.98	1.72	.0849
12. Availability of helicopter service	29	1.86	225	1.94	0.37	.7095
13. Quality Assurance Program	31	2.13	194	1.90	1.29	.1975
14. Critical Care and interfacility transfers	32	2.31	218	1.72	2.87	.0041

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(Specifically, the question was stated as, "Would the lack of a medical director be a concern for your service?") Perhaps this is due to the fact that paramedic services already have a closer established working relationship with medical direction.

The needs assessment also demonstrates that there clearly are different needs based on level of service. Basic providers noted that retaining EMTs, presumably volunteers, is much more of an issue than paramedic services for whom retaining is probably primarily a budgetary issue. It is also noteworthy that paramedic providers felt that interfacility transfers were more of a problem than basic providers did. The reason is not apparent, but it may be due to the fact that paramedics are asked more often to provide this service.

The differences in responses were even greater when service area was considered. There was clearly a relationship between level of service and service area (rural providers were more likely to be at basic level). The 36 paramedic services were evenly distributed between urban, suburban and rural, whereas 184 of 235 (78%) of the basic services were considered rural. In addition to the concern for "lack of medical director," urban providers were also more concerned about system abuse, interfacility transfers and political boundaries while rural providers noted greater problems related to recruiting and retaining.

If, in fact, rural providers are having substantial problems related to recruiting and retaining, the EMS system, which is 75% rural, is significantly stressing the need for EMTs. Stress within the EMT profession has been previously studied and job dissatisfaction was related to effect on family and lack of knowledgeable administrators.[2] In addition, it has also been noted that public perceptions and public awareness of the capabilities of rural emergency medical services is lacking.

Furthermore, physicians are no more likely than other citizens to be able to identify the skills provided by prehospital providers.[3] In Wisconsin, the Physicians Advisory Committee to the EMS Board is developing a handbook for local medical directors. The Wisconsin Chapter of the American College of Emergency Physicians has received a grant to explore methods of teaching medical direction.

Conclusion

According to prehospital providers, Wisconsin's EMS system has several identified needs. Many of the concerns center on personnel needs and financial constraints. All levels of EMS providers placed highest priority on the need for medical direction. In addition, rural providers in particular are concerned about retaining and recruiting EMTs. Although innovative technological solutions allowing prehospital defibrillation and airway management to occur at the basic level may address many of these problems, it is likely that system support and medical direction will continue to be major issues. For effective EMS service to continue and improve, it is crucial that physicians become active in EMS support and medical direction.

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Authors' note: *The prehospital provider survey was developed by the EMS Advisory Board. The opinions expressed are those of the authors, with approval of the EMS Advisory Board but do not necessarily reflect the opinions of the Section of Emergency Medical Services of the Department of Health and Social Services.*❖

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Seven reasons for Wisconsin physicians to oppose proposed legislation to legalize physician-assisted suicide

Michael J. Green, MD, MS, and Norman Fost, MD, MPH, Madison

In March 1995, State Representatives Frank Boyle (D-Superior), Tammy Baldwin (D-Madison) and State Senator Fred Risser (D-Madison) introduced identical companion bills (Assembly Bill 174 and Senate Bill 90) to the State of Wisconsin Legislature[1] to legalize physician-assisted suicide in this state. We believe Wisconsin physicians should oppose this legislation. We strongly sympathize with the underlying concern of the bills, namely that physicians need support in their efforts to reduce their patients' suffering, and to aid in their dying in appropriate instances. These bills however, are not a good way to accomplish such goals.

The proposed legislation permits a competent patient to request medications from his or her attending physician for the purpose of ending life. A physician would be authorized to prescribe these lethal medications (assisted suicide) provided that the patient is a Wisconsin resident, is 18 years of age or older, is legally competent to make such decisions, is terminally ill (defined as less than 6 months to live), and voluntarily requests aid in dying.

To implement the policy, an eligible patient must first make an oral request, then a written request in the presence of three witnesses after a 15-day waiting period, followed by a second oral request. The attending physician is obligated to ensure that the patient meets eligibility requirements and is properly informed about diagnosis, prognosis, consequences of, and alternatives to, taking lethal doses of medications. A consulting physician must review the case, and the attending physician must refer the patient to a psychiatrist or psychologist if there is concern about a psychiatric disorder. All requests are revokable, and no physician or health care facility can be charged with a crime for fulfilling such a request.

While these bills are considerably more modest than the failed 1993 version (Assembly Bill 755)[2], Wisconsin physicians should oppose this legislation for the following reasons:

1. It is not necessary.

A change in law is not needed. Wisconsin physicians can already write a prescription to a terminally ill patient for drugs the patient might use to kill him or herself,[3] as long as the physician does not intend their use for suicide. Often, supplying such medications, (e.g. morphine for pain) is part of good medical care for the terminally ill. Creating a law that explicitly condones the activity is not necessary, since the practice already occurs within the context of a private, trusting patient-doctor relationship.

2. It may inhibit aid for dying patients.

Although the proposed legislation is intended to reduce barriers to assisted suicide, it may paradoxically inhibit the actions it intends to advocate. Under the proposed bills, the state's bureaucracy is introduced into the privacy of the patient-doctor relationship. The bills require that physicians document requests for assisted suicide in the medical record and submit forms to the Department of Health and Social Services. This requirement may actually inhibit compassionate care of the dying rather than support doctors and their patients.[3]

Furthermore, the bills do not help those who need it the most. A patient with a debilitating, but non-terminal illness such as amyotrophic lateral sclerosis, would not be eligible for assistance, even though the patient may be suffering greatly and unable to help him or herself.

3. Patients lack a basic right to health care services in the state.

In the absence of universal, guaranteed access to health care for all patients, it is premature for Wisconsin to provide a legal right of patients to have a doctor assist in their dying. What is the message sent by a Legislature that guarantees a speedy death but not basic medical care that will promote and preserve a meaningful life? In the Netherlands, where assisted suicide is widely practiced with the tacit approval of the government, 99.4% of the population have health care insurance.[4] Before approving assisted suicide legislation, the state must ensure universal access to medical care.

4. Too many patients lack an ongoing relationship with a physician.

With the current successful efforts to turn medicine into a business, fewer patients have stable, long-term relationships with a doctor. Sanctioning

Continued on next page

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assisted suicide outside the context of a long-term, ongoing doctor-patient relationship is ill-advised, since many who request assisted suicide may not have explored other options for addressing their suffering. A patient who is sick and dying needs a compassionate physician he or she knows and trusts, not a law promoting easy access to killing. This legislation encourages stranger-assisted suicide by individuals like Jack Kevorkian. Wisconsin does not need a Jack Kevorkian.

5. The law would invite abuse.
In the Netherlands, assisted suicide and euthanasia are only permitted for competent adults who request it. Despite this rule, many Dutch physicians assist with the deaths of patients who are neither competent, nor request it. It has been estimated that in more than 1,000 cases each year (0.8% of all yearly deaths), doctors prescribe or administer drugs for the purpose of shortening a patient's life without an explicit patient request.[4-5] Physicians in the Netherlands disregard other rules as well; while required to report all assisted deaths to the medical examiner, an estimated 25% of doctors fail to do so.[4]

The proposed Wisconsin law differs from the one in the Netherlands in that it does not authorize active euthanasia. Under the proposed Wisconsin statute, physicians may not actively kill; they can only help patients kill themselves. However, physicians in Wisconsin, like physicians in the Netherlands, are not likely to comply with all the rules. If the bills are passed, we should expect the boundaries of assisted suicide to become blurred, and for some physicians to assist in the killing of incompetent or non-terminal patients as well.

6. Physicians currently treat pain and suffering inadequately.
Many physicians undertreat pain and inadequately address the emotional and physical needs of the dying.[6,7] This inadequate pain control compels some patients to request physician-assisted suicide.[8] Legalizing physician-assisted suicide provides too easy an escape from the obligation to address the underlying needs of the terminally ill. Before an assisted suicide bill is considered, the profession must do a better job addressing the pains, fears, and concerns of the dying. Unfortunately, the bills say nothing about physician education, and instead provide a convenient excuse not to learn such skills.

7. The right to die could become an obligation to die.
Patients at the end of life use health care resources disproportionately. In this era of cost containment and rationing, it is not difficult to imagine that a patient's *right* to request aid in dying could easily become an *obligation to* request such aid. Such social pressure for one to end his or her life, whether actual or perceived, would be unacceptable. The problem with making assisted suicide appear reasonable, as Herbert Hendin points out in his recent book on suicide in America,[9] is that those who do not request it may be seen as *unreasonable.*

Discussion
We do not believe assisted suicide is always wrong. On the contrary, there are cases where assisted suicide is an ethically acceptable and a compassionate response to a patient's suffering. As Dr Timothy Quill illustrated in his case study of Diane,[10] when a patient and doctor agree it may be appropriate for the patient to end his or her life, the decision to do something about it is difficult, thoughtful, and private.

We should note that New York (the state in which Dr Quill practices), like Wisconsin, has a law prohibiting physician-assisted suicide. Even so, the Quill case illustrates that a careful, thoughtful doctor who assists a patient in suicide in the context of a long-term relationship, will not be punished despite the letter of the law. To the best of our knowledge, no doctor in the United States has been successfully prosecuted for assisted suicide this century.[11]

It is noteworthy that even when doctors bring such actions to public attention, as Dr Quill did, prosecutions have not occurred. There is no stronger evidence for the reluctance to prosecute than the many cases of Jack Kevorkian, who has virtually begged to be prosecuted, so he can establish more clearly the rights of patients to have access to assisted death. Despite his efforts, and despite widespread criticism from the medical profession, he has thus far not been able to achieve a successful prosecution.

For all the reasons stated above, we believe physicians should oppose the proposed Wisconsin legislation to legalize physician-assisted suicide. In addition, if the proposed legislation were to become law, there would be a number of serious implementation problems that have yet to be addressed.[12] For example, should a physician introduce assisted suicide as an option to their terminally ill patients, or wait for the patients to bring it up? What if a physician disagrees with assisted suicide? How should a physician deal with family members who may disagree? What training is required to perform the service, and are physicians adequately trained at present? How should a physician deal with failed attempts? Should a physician assist in the suicide of a patient who would not desire it if other, presently unavailable resources were available?

These issues have not been explored, in or out of the medical profession. These complexities argue, at the least, for a "clinical trial," before such a radical change is unleashed on a widespread basis. Such a trial is presently occurring in the state of Oregon, which has passed a similar bill.[3,13] Its implementation has been delayed because of legal challenges, another reason for Wis-

consin to wait and learn from the experience of others.

What next?

We advocate a continuation of the present system, where the law in theory seems to prohibit assisted suicide, but in practice, is extremely tolerant. The rarity of prosecutions, and the absence of any successful prosecutions, documents societal tolerance and support for doctors who assist patients in the dying process. We believe the possibility of prosecution should be retained as a impediment to reckless or poorly considered assisted suicides. By facing the possibility of prosecution, doctors are required to think very carefully about the appropriate use of this option.

Removing all legal risk creates two problems. It opens the door to abuse, which would result in wrongful and premature deaths of patients who could have meaningful, extended life. And by creating new bureaucratic requirements for the most private of decisions, it would unwittingly reduce the ability of patients and doctors to negotiate the circumstances of death.

Any system of restraint involves trade-offs.[14] The present system may tilt too far in inhibiting doctors and patients from discussing assisted suicide, because of the false belief that a physician will be prosecuted for aiding an appropriate patient in dying. The solution to that problem is education of doctors and patients, so that they understand the extraordinary tolerance which the legal system has granted in this area. The system proposed by Representatives Boyle and Baldwin risks the worst of both worlds: for some patients and doctors, it may inhibit assisted suicide even more than the present system. And for others, it may legitimize inappropriate, premature death for those who need help and hope, not a poison pill.

Acknowledgements

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Note: The views expressed are those of the authors, and not necessarily those of the Fellowship or the University of Wisconsin Medical School.❖

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Stark self-referral rules burdened with complexities

Kalisa Barratt, JD and Alyce Katayama, JD

On Aug 14, the Health Care Financing Administration (HCFA) published final rules interpreting the Stark I self-referral law. These rules came over 4 years after the law was originally enacted and significantly revise the proposed rules issued in 1992. The regulations (excluding the reporting requirements) became effective Sept 13, 1995. (The terms "rules" and "regulations" are used interchangeably throughout this article.) Although these rules address only Stark I's clinical laboratory services referrals, HCFA has stated "that a majority of its interpretations in this final rule will apply to Stark II's other designated health services" referrals as well. This article reviews some of the more significant changes made by these highly complex regulations. Because of the complexity of the revisions, the SMS recommends that physicians review the rules with qualified legal counsel to determine their impact on any current referrals for any of the "designated health services."

I. Origin and Objectives of Stark I

In 1989, the Office of the Inspector General found that at least 25% of the nearly 4,500 independent clinical laboratories at that time were owned in whole or in part by referring physicians. The report further revealed that Medicare patients of referring physicians who owned or invested in the independent labs received 45% more clinical laboratory services than all other Medicare patients. The OIG concluded that "increased utilization of clinical laboratory services by patients of physician-owners cost the Medicare program $28 million nationally in 1987." In response to these concerns, the Stark I anti-self-referral law was passed.

Stark I generally prevents a physician from referring a Medicare patient (Stark II added Medicaid) for clinical laboratory services to an entity with which the physician or physician's immediate family member has a financial relationship. The self-referral ban does not prevent a physician or family member from having an ownership interest in a facility as long as no prohibited referrals to this facility are made, nor does it apply to a facility that does no Medicare or Medicaid business. However, the concept of a referral under Stark I is quite broad. It includes any request by a physician for, or ordering of, any item or service for which payment may be made under Medicare Part B. This includes a request for a consultation with another physician but does not generally include a request by a pathologist for clinical diagnostic laboratory services and pathological examination.

II. The Final Rule

A. Changes from the Proposed Rule.

HCFA has extensively rearranged the regulations from those proposed in 1992, and has added numerous provisions from Stark II which are applicable to clinical laboratory services and which have retroactive effective dates to 1992. The final rule also responds to 299 public comments on the proposed rule. Following are some of the key changes seen in the final rule (some of which are discussed more completely below.

- HCFA has revised the definition of "compensation arrangement" to clarify that it applies to both direct and indirect arrangements.
- The definition of "group practice" has been fine-tuned.
- The definition of "remuneration" has been revised to provide that forgiveness of debts, certain payments, and the furnishings of certain items, devices, and supplies, are not considered remuneration if they meet specified conditions.

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- The following words have been defined: "clinical laboratory services," "direct supervision," "hospital," "HPSA," "laboratory," "members of the group," "patient care services," "physician incentive plan," "plan of care" and "transaction."
- The in-office ancillary service exception has been modified.
- Services furnished by a federally qualified HMO to individuals enrolled in the organization and services furnished in an ASC or ESRD facility or by a hospice, and included in the ASC rate, ESRD composite rate, or per diem hospice charge, respectively, have been added as general exceptions.
- The publicly-traded security exception has been revised.
- The rural provider exception has been revised by requiring that substantially all (i.e. 75%) of the tests furnished by the entity be furnished to individuals residing in a rural area, instead of requiring that the majority of tests referred to the rural laboratory be referred by physicians who have office practices located in a rural area.
- A revised space rental exception and a new equipment rental exception have been added.
- An exception for certain group practice arrangements with a hospital has been added, as has an exception for payment by a physician to a laboratory or other entity in exchange for certain items and services.
- A bona fide employment relation exception has been added.
- A personal service arrangement exception has been added to replace the proposed service arrangement with non-hospital entities exception.
- The reporting requirements for financial relationships have been revised.

B. Important Concepts and Definitions.

The definition of "immediate family members" included in the 1992 proposed rules was maintained. "Immediate family members" include spouses, natural or adoptive parents, children, siblings, step-relations, in-laws, grandparents, grandchildren and their spouses. Stark's "clinical laboratory services" definition is based on tests categorized by the CDC under CLIA. Thus, the CDC is the logical entity to contact if questions arise. Clinical laboratory services falling under Stark include biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological or other examination of materials derived from the human body for the purposes of providing information for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of human beings.

The regulations clarify that "financial relationship" includes a relationship that is, either direct or indirect, between a physician or physician's immediate family member and an entity in which the physician or immediate family member has an ownership or investment interest. The ownership interest can be through equity, debt or other means and includes an interest in an entity that holds an ownership or investment interest in any entity providing laboratory services or has a compensation arrangement. Compensation arrangement has now been defined as any arrangement involving any remuneration, direct or indirect, between a physician (or immediate family member) and an entity. This would include not only compensation paid to physicians for services rendered, but also payments for rent, interest on loans and, most likely, even discounts on goods and services.

III. Exceptions to Prohibitions.

Exceptions to the broad general referral prohibition fall into three categories: (1) those applicable to all financial relationships; (2) those applicable only to ownership and investment interests; and (3) those applicable to compensation arrangements. A physician should not assume that his or her referral practices satisfy the new regulations because they previously satisfied the 1992 proposed regulations. Following is a discussion of some important exceptions in light of changes found in the new final rules.

A. Exceptions Applicable to All Financial Relationships

1. In-office Ancillary Services

The final rules made three notable changes to the in-office ancillary services exception. The first change addressed the level of supervision a physician must perform when the physician is not conducting the services personally. The 1992 proposed rules allowed physicians to refer patients for in-office ancillary services and not violate the prohibition if the services were provided by an employee who was "personally supervised" by the physician. The final rules require that the services be performed by persons who are "directly supervised" by the physician or another physician in the same group practice. "Di-

rect supervision" is defined to mean that a physician must be present in the office suite and immediately available to provide assistance and direction throughout the time services are being performed. Thus, the proximity of the lab to the physician's office now becomes critical. Although the persons performing services must be directly supervised, they need not be employed by the physician or his or her group.

The final rules have also changed the requirements for the location where the services are furnished. Now, in order to qualify for an exception, the services must be furnished in a building in which the referring physician furnishes physician services unrelated to the furnishing of clinical laboratory services. If the services are furnished by a group practice, the services may be provided in a building that is used for "some or all of the group's clinical laboratory services." The 1992 rule allowed group practices to furnish services only in a building that was used by the group practice for centrally furnishing the group's clinical laboratory services.

Finally, the in-office ancillary exception only applies if the services are billed by the physician performing or supervising the service; the group practice of which the performing or supervising physician is a member; or, an entity that is wholly owned by the physician or the physician's group practice. However, note that under Stark II, if a physician is a member of a group practice (see below), he or she must bill for services provided under the group number and not the physician's personal billing number. This billing may also affect the group's qualification for exception.

It is interesting to note, however, that the preamble to the rules specifically addresses whether a lab can accept referrals from outside physicians who do not have a financial relationship with the lab. In that case, the preamble points out, the lab is acting as an independent laboratory because the services are not performed as an adjunct to the patient care services of the physician/owner. The referral can be accepted and these services should be billed by the laboratory under its assigned Medicare billing number.

2. Group Practice Exception

Stark I's prohibitions do not apply to physicians' services that are either personally furnished or furnished under the personal supervision of another physician in the same group practice as the referring physician. The new rules have made several changes to the group practice exception.

First, "group practice" has been redefined. Group practice means a group of two or more physicians, legally organized as a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan or similar association that meets certain conditions. Each physician member of the group must furnish "substantially all" of the patient care services that the physician routinely furnishes to his or her patients. Patient care includes medical care, consultation, diagnosis and treatment. "Group member" means physician partners and full-time and part-time physician contractors and employees during the time they furnish services to patients of the group practice that are furnished and billed in the name of the group (under Stark II, under the billing number assigned to the group).

The second change to the group practice exception is the threshold for substantially all of the patient care services. Patient care services are measured by the total patient care time each member spends on those services. "Substantially all" for a group member is now defined as at least 75% of his or her total patient care services time (whether or not it involves direct patient encounters). A physician who spends 30 hours a week out of a forty hour a week practice providing patient care services for a group practice will have met this requirement. As long as the entire group, as a whole, meets the 75% require-

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ment it is permissible for some group members to fall substantially below the threshold.

This percentage threshold was lowered from the proposed rule's 85%. The comments to the rules note that the change was made in fairness to physicians who practice in rural areas where the scarcity of physicians usually equates to less time devoted to a group practice, but applies to group practices in urban communities as well. This "substantially all" requirement does not apply to any group practice located solely in a Health Professional Shortage Area (HPSA). The change was also made to allow physician groups additional flexibility in hiring part-time and temporary physicians.

A group practice is also required to submit a yearly written statement to its carrier attesting that it met the 75% standard. A group that intends to meet the definition of a group practice in order to rely on one of the exceptions to the referral prohibition must submit this statement to the carrier by Dec 12, 1995. The attestation must state that the information furnished is true and accurate and be signed by a representative of the group. If the group did not meet the standard, any Medicare payments made for clinical laboratory services furnished by the group during the 12-month period that were conditioned on the standard being met are overpayments.

B. Exceptions Related to Compensation Arrangements

The new regulations clarify Stark's exceptions relating to compensation arrangements. These exceptions relate to office space rental, rental of equipment, bona fide employment relationships, personal service arrangements, physician incentive plans, physician recruitment, isolated transactions, and certain arrangements with hospitals, group practice arrangements with hospitals and physician payments. Some of the more important exempt compensation arrangements are discussed below.

Office Space and Equipment Rental

In order for a rental payment to be exempt from Stark I and not considered a financial relationship the following requirements must be met:

a. The rental agreement must be in writing, signed by the parties, for a term of at least one year.

b. The space or equipment rented must not exceed that which is reasonable and necessary for the legitimate business purpose of the lease.

c. The rental charges are set in advance and consistent with fair market value. Fair market value means the value of the rental property for general commercial purposes. With respect to a leased space, this should not reflect any additional value a property may have by virtue of its proximity to a source of the patient referral. For example, a rental charge should not be increased because the lessee laboratory is conveniently located downstairs from the lessor physician's office.

d. The rental charges should not take into account the volume or value of referrals or other business generated between the parties.

e. The agreement should be commercially reasonable even if no referrals were made between the parties.

Bona Fide Employment Relationships

A financial relationship resulting from employer-employee status will not violate Stark I as long as a

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physician or a physician's immediate family member has a bona fide employment relationship with the employer. The conditions which must be met to constitute a bona fide employment relationship are: the employment must be for identifiable services; compensation must be consistent with the fair market value of the services and not vary based on the volume or value of the services; and, the payment must be commercially reasonable even if no referrals were made to the employer. This exception does not prevent an employee from being paid a productivity bonus based on services they personally performed.

Isolated Transactions

Isolated transactions such as a one time sale of property or a practice will not be considered a financial relationship as long as the amount is consistent with fair market value, does not take into account the volume or value of services and would be otherwise commercially reasonable. In general, there can be no additional transactions between the parties for 6 months after the isolated transaction.

C. Exceptions Related to Ownership or Investment Interests

A physician may refer patients to an entity even if the physician has an ownership interest in the entity if the entity is a large, publicly traded company or mutual fund, a rural provider, a hospital in Puerto Rico, or other hospitals if certain criteria are met.

The rules indicate that a physician may own securities (including shares or bonds, debentures, notes or other debt instruments) listed for public trading. The securities must be in a corporation that as of Jan 1995, had assets in excess of $100 million or had stockholder equity exceeding $75 million at the end of the corporation's most recent fiscal year or on average during the previous 3 fiscal years.

A physician may have an ownership interest in a hospital if the referring physician is authorized to perform services in the hospital and the physician's ownership interest is in the entire hospital rather than a distinct part or department or, until Jan 1, 1995, the referring physician's ownership did not relate (directly or indirectly) to the furnishing of clinical laboratory services.

IV. Reporting Requirements

The rules indicate that HCFA will be developing a reporting form and instructions to providers for submitting information to HCFA regarding reportable financial relationships under Stark I. Except for the group practice attestation discussed above, providers are not required to report relationships until this form is developed. Once developed, requests for information will come from the provider's Medicare intermediary or carrier. Providers will then have 30 days to submit the information. The report must include the name and UPIN of each physician who has or whose immediate family member has a financial relationship with the entity; the nature of the financial relationship between the two; and, the items and services provided by the entity. An exception to the reporting requirements exists for entities that provide 20 or fewer Part A and Part B items and services during a calendar year. Failure to report the information can result in a penalty of up to $10,000 per day.

V. Application of the Final Rules/Interaction with Other Laws

HCFA has rejected arguments that enforcement of Stark I should be limited to referrals occurring after publication of the final rule. However, HCFA has indicated that sanctions which result from interpretations of the final rules will not be applied retroactively. Although this article only addresses Stark I prohibitions, it is important to note that other laws, including the Medicare and Medicaid anti-kickback statute and the fraud and abuse safe harbors promulgated by rule, do not cleanly dovetail with Stark. Conduct falling under a Stark exception may still violate fraud and abuse laws. Likewise, conduct coming within a fraud and abuse safe harbor may violate Stark.

Conclusion

Stark and its new final rules weave an intricate and tangled web that may trap unwary providers. Even with the new rules' guidance, adequately identifying conduct protected by the exceptions is a difficult task - one that should be left to a competent health care attorney.

Meanwhile, Pete Stark, who started it all, has introduced a new bill (H.R. 2173) to "improve" both laws. Both the House and Senate Medicare/Medicaid reform plans would move in the opposite direction, making major cutbacks in the Stark law. Among the proposed changes would be that a compensation arrangement would not create a bar to referrals. The list of designated health services would be reduced to four: clinical laboratory; community pharmacy; MRI and CT; and, physical therapy. The in-office ancillary exception would be modified by eliminating the requirement that there be direct physician supervision of non-physician ancillary service personnel. New exceptions would be added including one for shared facility services for physicians in the same building. Stay tuned for further developments.❖

Settling an estate

by Michael J. Dolan, CLU,ChFC, Madison

When there is a death in the family, survivors must move toward settling the estate. Here's what must be done:

- Secure several certified copies of the death certificate from the funeral director; they'll be needed in applying for life insurance and Social Security benefits, transferring title to property, and settling banking and legal matters.

- Submit life insurance claims promptly. And check all policies, since some lapsed whole life insurance policies may still have benefits payable. There may also be benefits due under other policies; depending on the cause of death, claims may be filed under automobile insurance, for example, or under an accident policy. Don't overlook any group policies the deceased may have had through a union, professional organization, even a credit card company.

- You may have a choice of taking life insurance proceeds in a lump sum or in installments. Discuss the options with your life insurance agent, and think carefully about which option is right for you.

- Make a thorough search for important documents. Don't overlook insurance policies, business agreements, loan agreements, securities, bankbooks, deeds, tax records, etc.

- Organize all bills so that outstanding bills can be paid. Check out details of installment loans and credit card accounts before making payments; there may be credit insurance in force which will pay off the account balance at death. Be careful, too, about paying only bills which are actually due. Some thieves prey on bereaved families, suggesting that money is owed when it is not.

- Contact the deceased's employer and inquire about benefits which may be due. These benefits may include group life or health or disability proceeds, vested pension fund holdings, accrued pay, credit union balances, etc.

- If you are a surviving spouse, speak to the employer about continuation of health insurance. Federal legislation makes many widows and widowers eligible to continue group health insurance, by paying for it, for a certain number of months. This can provide an important transition period, giving you time to secure your own coverage.

- Look into any government benefits which may be available, from Social Security, the Veterans Administration, or other agencies.

Michael J. Dolan, CLU,ChFC

- Arrange to transfer the title of jointly-held property; a lawyer can help you here.

- Arrange to have the will probated, so that the estate can be settled and the proceeds distributed as soon as possible. Although final settlement can take a year or more, it may be that living expenses can be distributed from the estate before it is settled.

- A federal estate tax return will have to be filed if the gross estate exceeds $600,000; this form must be filed within 9 months after the date of death. State taxes vary from state to state. An attorney can help you here as well. ❖

Dolan is vice president and chief operating officer of SMS Insurance Services and a member of the National Association of Life Underwriters.

Female medical students outnumbering men; medical schools seeking more female faculty, mentors

Genie Campbell, special to *WMJ*

It's a sign of the times. Women are enrolling in medical schools in unprecedented numbers. But once they earn that degree, will they be able to advance at the pace of their male colleagues? Does medicine have a "glass ceiling" for women? Or, are female physicians simply choosing a different path for their careers?

Christine Chuppa, 23, a second-year medical student at the UW-Madison, knew on entering high school that she wanted to become a physician. Demonstrating a strong aptitude for science, Chuppa, from West Allis, was encouraged by her family and teachers to pursue medicine as a career.

"Right now I'm thinking about going into gynecology because I'm interested in helping women and I'm also interested in women's health issues," said Chuppa.

What a difference a generation can make.

Chuppa's mom was equally strong in science, but in keeping with the times, she was urged to become either a teacher or nurse. She chose the latter.

Across the country today, women are entering medical schools in record numbers, and even, in some cases outnumbering men in the college ranks. Of the 143 members of the class of 1999 at the University of Wisconsin Medical School, 73 are female and 70 are male.

Although this represents an historical milestone for the university, these statistics are hardly surprising. The number of women earning medical degrees from the UW has been climbing steadily over the past decade. In 1988, the school's incoming class was 34% female. By 1990, 38% of first-year students were women and just a year ago, women lagged behind men by just one--71 as opposed to 72.

At the Medical College of Wisconsin in Milwaukee, 71 of the 204 students accepted this year, or about 35% of the class, were women. Within the last 10 years, that percent has varied anywhere from 33 to 43%, said Lesley Mack, director of administration and registrar.

Continued on next page

Christine Chuppa (foreground) and fellow students.

Campbell is a Madison-based, free-lance writer and former features editor of the *Wisconsin State Journal*.

Continued from previous page

No shortage of applicants

Despite concerns over how government intervention will affect the delivery of health care in the United States, young adults are clamoring to become physicians. In 1994, more than 45,000 people (or almost double the number 8 years ago) applied at American medical schools. And though the final count is still out for 1995, last year's record is expected to be broken. Competition is fierce. The overall undergraduate grade point average for students entering either UW's School of Medicine or the Medical College of Wisconsin was an unprecedented 3.6.

As Wisconsin, so goes the nation.

Out of a total of 125 medical schools, 18 had more than 50% women in their freshman classes last year, said Janet Bickel, associate vice president for institutional planning and development for the Association of American Medical Colleges (AAMC). These schools include Brown, Yale, Harvard and Johns Hopkins. Once 1995 statistics are compiled, Bickel, based in Washington, DC, expects that number to grow to as many as 22.

"While I can't predict what will happen in the future, I wouldn't be surprised if women's acceptance rate overall exceeds men ," said Bickel, "because women tend to choose primary-care careers at a higher rate than men and the mission of many schools, in keeping with he national health focus, is to graduate more primary-care physicians."

Yet, every bit as significant as the increasing number of women entering medical school, said Bickel, is the fact that, within the past 3 years, "women have been accepted in the exact proportion in which they applied."

That hasn't always been the case. Although never practiced at the UW, some medical schools in the past "capped" the number of female students accepted, no matter how promising their credentials, for fear they lacked the necessary discipline and devotion to medicine. When Dr Elaine Mischler, professor of pediatrics in the Division of Critical Care and Pulmonology at the Medical College of Wisconsin, graduated from University of Pennsylvania's Medical School in 1970, she was one of only five women, as opposed to 120 men, allowed into the program.

Wanted: female faculty

Before joining the staff at MCW earlier this year, Mischler was professor of pediatrics and associate dean of students and gender issues at the UW Medical School. She became the first female associate dean ever employed by the school when she accepted the position in 1992.

Ironically, while women are entering and graduating from medical schools in record numbers, they have yet to make a dent in the hallowed halls of academic medicine and leadership.

Nationally, women make up 25% of full-time medical-school faculty, primarily at the rank of assistant professor. But, across the country, there are only three women who are full deans, said Bickel.

At the UW's medical school, the percentage of full-time women faculty is about 18 percent. The only female department head, Judith Leavitt, recently stepped down after 12 years as chair of the history of medicine department to devote more time to research.

"Yes, we have a long way to go in order to get women into the upper echelon in medical school," commented Leavitt. "We are trying and I hope moving in the right direction," she added.

Dr Philip Farrell, dean of the UW Medical School, acknowledges that the number of women in prominent academic, medical positions is limited at this point because there is a natural "lag period" from the time when women enter medical school in greater numbers to the time they move through the ranks into leadership positions. "I think we will start to see major changes in the early period of the next century," said Farrell.

Few role models available

First year medical student Kathryn Meyer, 28, whose encouragement to become a physician was self-induced, after having worked in a hospital as a nurse practitioner, is quite cognizant of the fact she sees very few women standing in front of the classroom.

"It would be nice to have more female faculty, particularly to act as role models," she said. "In the beginning, I was a bit intimidated by the length of time it took to become a doctor. I also didn't think it would be possible to mix a medical career with having a family. But the more I worked in health care, the more I saw women successfully doing it." Meyer is married and commutes to classes from Appleton.

To make up for a lack of female mentors at the university level, one campus organization, Women in Medicine, is successfully teaming up first-year medical students with practicing female physicians in the area. Another offshoot of the group, Medical Student Volunteer Corp., trains female medical students to counsel battered women in emergency rooms.

While associate dean at UW's Medical School, Mischler headed up a task force to address gender issues within the Medical School. The result was a document, *Women in Science, Engineering and Mathematics (WISE) Medical School Task Force Report*, released in July of this year. (The UW-Madison Dean's Council had earlier requested such a study for schools of science, engineering and mathematics.)

"One thing I think I was able to do as dean of students was empower the women," said Mischler. In quoting a colleague, Leah Dickstein, a psychiatrist at the University of Louisville School of Medicine, she added: "We need good men of conscience and women of cour-

age to work together so the professional workplace is good for all."

Mischler champions the vital role mentors play, "women who have made it to higher elevations of academic medicine often had a man sponsor them," and achieving a "gender-equal environment," that isn't necessarily the same but equal. It means eliminating the "micro-inequities" that usually escape conscious attention, like not scheduling a power meeting at 7 a.m. when many women are frantically trying to get their children out the door, she said.

"Men are not overtly trying to keep women from gaining power. You just have to wake them up and make them understand," she commented. On the other hand, women who are already in leadership positions need to "speak out and pave the way for other women."

Dean Philip Farrell and students.

Doubling efforts

In a recent commentary for the *Western Journal of Medicine*, Bickel wrote: "The term 'glass ceiling' is not helpful in understanding why more women are not advancing into policy-making leadership positions. Ceiling implies that the powers-that-be are deliberately limiting the number of women moving ahead. In reality, many deans and department chairs are concerned about the paucity of women candidates for top positions."

Farrell concurs. "It is a great concern because more women would clearly enrich the profession of medicine and teaching activity; it's only a natural revolution for them to be in leadership positions. We are bending over backwards to identify women candidates and we are very confident that some associate dean positions we are in the process of hiring will be filled by women," he said. "Our No. 1 goal is to increase the diversity of our staff and students in order to enrich our learning environment and to better reflect the society we serve."

Attracting female candidates is not always easy. Out of 235 applicants for a recently opened assistant professorship, only one was a woman.

The fact is, according to one national study about to be published, some qualified women in medicine don't aspire to be in leadership positions because of the effect it will have on other parts of their lives, particularly child-rearing.

More career flexibility will be required in the future, said Bickel. "With 60 percent of women academic physicians married to other physicians, medicine will have to change its institutions. The old way of demanding single-minded dedication to medicine needs to be recast because it depended on a full-time backup for the rest of life's activities."

Slowly, the Old Guard is changing, though probably not as fast as some women would prefer. The UW Medical School is pursuing increased mentoring, greater schedule flexibility and generally, an environment more supportive of women's needs, according to Farrell.

Currently, two women are "job-sharing" a pediatric residency program. "Instead of graduating in 3 years, they work half time and graduate in 6 years. We can do the same thing with faculty positions. I believe we've made great progress with the student body and we need to achieve the same level of progress with faculty. It just doesn't happen out of the blue," said Farrell.

Yet, even though policies must be continually updated and improved, "some (policies) already in place that particularly benefit women are not well understood or utilized," continued Farrell. "We do have examples of people who did have an opportunity to change their tenure clocks or take a prolonged leave of absence but didn't do it. Some women are concerned if they do take, for instance, a pregnancy leave, it will penalize them in career advancement because some areas of research are very fast moving."

More primary care training ahead

Along with a push to see more

Continued on next page

Continued from previous page
women in medicine policy-making roles, is a "significant" change in curriculum, though the two aren't necessarily linked, said Dr. Sheldon Horowitz, pediatrician and associate dean for medical education at UW's Medical School.

"Added to UW's curriculum is a 4-year generalist program, not because we have more women but because there is a national push for more primary care physicians and we agree with that," Horowitz said. There is also an increased focus on such areas as risk assessment, doctor-patient communication, geriatrics, nutrition and women's health. And a new third-year primary-care clerkship, begun in 1990, sends students out to doctor offices and clinics in 24 Wisconsin cities for more hands-on experience.

Three years ago, 14.6% of U.S. medical school seniors wanted to become general internists, general pediatricians or family practice physicians. Today, 27.6 percent of medical school seniors say they plan to pursue more people-oriented, primary care careers. Also, the average age of medical students is creeping up ever so slightly as more and more students like Meyer decided to switch careers.

"I worked for a surgeon and I enjoyed that," said Meyer. "But I wanted to have more control and be more involved in taking care of patients throughout an entire spectrum of illness."

"There is also a growing awareness by students of the realities of the marketplace," said Dr. Michael Whitcomb, senior vice president for medical education at AAMC in a recent *New York Times* story.

For some, it's strictly a matter of supply and demand. As the medical industry becomes more cost conscious, primary care is where the jobs are.❖

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SMS Women in Medicine Leaders

A milestone was reached this year when more women than men registered in the first-year class at the University of Wisconsin-Madison Medical School. We asked three of our women leaders at the SMS their opinions on this milestone, what motivated them to choose the field of medicine, why they became involved in SMS and finally, where they see the future of women in medicine headed.

"I think it's wonderful to see more women going into medicine. It will be fascinating to watch and see where these women will practice. When I was in high school, no one ever encouraged me to go into medicine, in fact they said it would be an impossible goal. While women still struggle in moving up the professional ladder, I am hopeful, because I see the tide turning."

Sandra Osborn, M.D., Madison, Pediatrician
SMS Speaker of the House

"I believe that every physician (man and woman) needs to participate in State Medical Society activities to the extent she or he is able. At this time more than ever we must all be involved with the continuing evolution with medical care."

Pauline Jackson, M.D., La Crosse, Psychiatrist
SMS's first woman president (1993-1994)

"Neither altruism nor academic challenge motivated me in pursuing a medical career. The challenge for me arose in kindergarten when my teacher asked what I wanted to be when I grew up. I said I wanted to be a doctor. She corrected me and stated, 'girls are nurses, not doctors.' From the age of five, I never wavered in my resolve to become a physician, and my choice to practice primary care has given me opportunities I never thought possible.

"There is dissonance in medicine. We work in a strained environment. We practice in a world that is regulated and imposes many restrictions on the delivery of health care. We have tension, demands and constraints that formerly did not exist. Organized medicine is evolving; my contribution has been to offer diversity in management style. The strength of women as leaders comes from their natural collaborative style and ability to build consensus."

Susan Turney, M.D., Marshfield, Internist, AMA Delegate

Wisconsin women have a long history in medicine

Genie Campbell, special to WMJ

When Dr Charlotte Burns, 57, an ophthalmologist with Dean Medical Center, graduated from the University of Wisconsin Medical School in 1962, she was one of only 10 women in a class of about 100.

If there was prejudice against women, "I didn't really notice," Burns related. "It didn't bother me; you do your job whether you are male or female. It's not a determining factor in how you perform or accomplish things."

Unlike many young women at the time, however, Burns had the support of two excellent role models--her father, Robert Burns, former chair of the Department of Orthopedics at the UW Medical School; and, even more importantly, her mother, Charlotte Calvert, the first female intern at University Hospital, who graduated from UW's two-year medical program in 1921, then completed her degree at the University of Minnesota.

Though she quit practicing to raise a family long before Burns applied to medical school, Charlotte Calvert was 100% behind her daughter's dream. Robert Burns also lent his support after being convinced his daughter would persevere. Initially, related Burns, her dad was very skeptical. "He didn't want to see me get hurt."

While teaching and practicing out East, Robert Burns had witnessed overt prejudice against female medical students. In one incident her father had seen a door slammed in a woman's face by a male colleague, she said.

Today, Burns is married to physician James Burns, trauma surgeon at Rockford Memorial Hospital and a part-time physician with MedFlight in Madison. Their daughter, Barbara Burns, a pre-med student, is planning to carry on her family's tradition by becoming a physician, too.

UW's Medical School began as a two-year program in 1907, at which time it was commonly referred to as the "Attic Medical School" because

Graduating Class of 1927

many of the laboratories were set up in unused space in the attics of the science and agricultural buildings. It wasn't until 1925, upon the opening of University Hospital, that the program was expanded to a full 4 years. That first graduating class of 1927 consisted of six women and 19 men.

Rima Apple, associate professor of women's studies at the UW-Madison, and Judith Leavitt, history of medicine professor, found the percentage of women in this first graduating class quite "striking," they wrote in a back issue of *Wisconsin Academy Review*, because "in the early decades of the 20th century, some coeducational medical schools had established quotas for women of approximately 5 percent."

After that first year, however, the outlook for women changed appreciably.

In 1928, there were no women graduates; in 1929, five in a class of 44 were women and in 1930, only two out of a class of 38 were women.

"Only in the late 1970s, did the percentage of women medical graduates rise to the height of the 1927 class, and with some modulation it has remained relatively high," they stated, especially in comparison to other medical schools across the country. It must also be noted, however, as well that the number of female applicants to UW's Medical School remained relatively low until the early 1970s.

Though the UW never formerly limited the number of women accepted into medical school or expressed blatant disdain for female applicants, the male bastion did, in earlier years question a woman's commitment to medicine.

Charles Bardeen, dean of the Medical School from 1907 to 1935, supported the "idea of women physicians" but, according to Leavitt and Apple, was quoted once telling a female applicant that "women in medicine never go on to use it" and "the state couldn't afford to train them if they weren't going to use their medicine because there were good men who wanted to go into it."

Unfortunately, Bardeen died before the graduation of one of his own daughters from medical school.

During the 1960s and 1970s, women began applying to medical schools in increasing numbers although like a majority of women entering other male-dominated fields at that time, their motives and devotion were unfairly scrutinized. Women--but not men--were interviewed regarding their plans for marriage and whether it might make them decide to drop out of school.

Today, according to Dr Catherine DeAngelis, professor of pediatrics and vice dean for academic affairs and faculty at Johns Hopkins School of Medicine, there is almost no difference between men and women medical students in academic performance, in rate of attrition or, since 1990, in scores on advanced standardized tests. Out of school, some differences do emerge, she said in a speech earlier this year in Madison. Women are considerably more prone than men to enter pediatrics, psychiatry, and gynecology and obstetrics, but much less likely to become surgeons. Female physicians outlive male physicians by 8 years and they work slightly fewer hours, especially during their child-bearing years.❖

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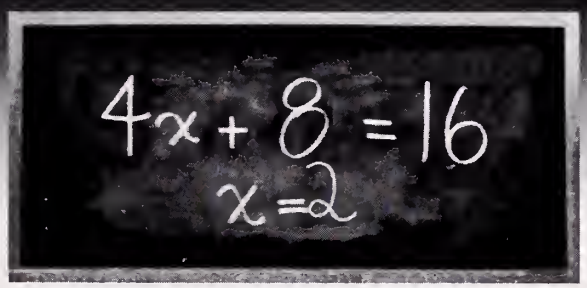

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AMA awards

THE WISCONSIN PHYSICIANS listed below recently earned AMA Physician's Recognition Awards for October. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates members of the SMS.

* Cleveland, David A.
* Dart, Richard A.
Dawson, Michael J.
* DeStefano, Frank
* Faber, John W.
Fishman, Paul A.
Fletcher, Fred W.
* Hoffmann, David M.
* Knoch, Frederick W.
Krummel, Stephen J.
Logrono, Roberto
* Medich, Michael G.
* Miller, Owen E.
* Olson, Stuart K.
* Ozkazanc, Ismet B.
* Paloucek, James T.
Rahimi, Abbas
* Reuter, Mark G.
* Singh, Narinder
* Turney, Susan K.
* Varghese, Abraham

David C. Olson, MD
Lyle L. Olson, MD
Ronald W. Olson, MD
David W. Ovitt, MD
Thomas C. Pagedas, MD
Somrat Pakpreo, MD
Howard J. Paley, MD
Steven D. Pals, MD
Fred D. Panzer, MD
Byung H. Park, MD
Harrison W. Parker, MD
John G. Parrish, Jr., MD
Ewald H. Pawsat, MD
John R. Pellett, MD
Edward L. Perry, MD
Mohan Peter, MD
John R. Petersen, MD
John T. Petersik, MD
Stanley E. Peterson, MD
Thomas H. Peterson, MD
Louis R. Pfeiffer, MD
Philip E. Pier, MD
Kenneth G. Pinegar, MD
Er Chang Ping, Jr., MD
L. Maramon Pippin, MD
Evan F. Pizer, MD
Peter V. Podlusky, MD
Glifford R. Poplar, MD
John F. Poser, MD
Rolf F. Poser, MD
Leon J. Radant, MD
Douglas Raether, MD
Robert W. Ramlow, MD
Vani Ray, MD
Arthur L. Reinardy, MD
Everett W. Reinardy, MD
Marcia J.S. Richards, MD
John E. Ridley, III, MD
Thomas A. Reminga, MD
Sharon L. Rink, MD
Richard G. Roberts, MD, JD
Barry L. Rogers, MD
Theodore Rowan, MD
William T. Russell, MD
Dennis K. Ryan, MD
Martin H. Sahs, MD
John J. Satory, MD
Wendelin W. Schaefer, MD
Sally M. Schlise, MD
Mary H. Schmidt, MD
Joseph P. Schneider, MD
Joseph B. Schrock, Jr., MD
George S. Schroeder, MD
Rudolf E. Schuldes, MD
Caryn I. Schulz, MD

Weldon D. Shelp, MD
Jean H. Short, MD
Gerald H. Schroeder, MD
Walter R. Schwartz, MD
Steven M. Schwimmer, DO
Robert J. Scott, MD
Veronica Solis-Rohr, MD
Chonsham Sooknandan, MD
Armond H. Start, MD
Charles L. Steidinger, MD
Paul H. Steingraeber, MD
Walter P. Stenborg, MD
Scott M. Stillwell, MD
Thomas R. Stoiber, MD
Richard H. Strassburger, MD
Jack Strong, MD
Robert J. Swoboda, MD
Thomas A. Taft, MD
Yoshiro Taira, MD
Daniel C. Tanty, MD
Stewart F. Taylor, Jr., MD
Gamber F. Tegtmeyer, Jr., MD
Leon Cass Terry, MD
William L. Treacy, MD
Darold A. Treffert, MD
Philip F. Troiano, III, MD
Goro Tsuchiya, MD
Her Lang Tu, MD
Allen O. Tuftee, MD
Lee M. Tyne, MD
Richard H. Ulmer, MD
Steven J. Vacek, MD
Kenneth M. Viste, Jr., MD
Vito N. Vitulli, MD
Wess R. Vogt, MD
W. Gregory Von Roenn, MD
Gilbert S. Wadina, MD
John P. Walsh, MD
John E. Walz, MD
James D. Warrick, MD
Stephen B. Webster, MD
John B. Weeth, MD
Maxwell H. Weingarten, MD
Paul A. Wertsch, MD
Frank C. Williams, Jr., MD
Edward Winga, MD
Margaret C. Winston, MD
John H. Wishart, MD
Raymond W. Witt, MD
Leonard W. Worman, MD
Carlos C. Yu, MD
Randal J. Zabrowski, MD
Raymond C. Zastrow, MD
James F. Zimmer, MD
Edward Zupanc, MD ❖

Physician briefs

Guirish A. Agni, MD,* specializing in internal medicine, has joined Dean Medical Center's Stoughton Clinic. He earned his medical degree at Maulana Azad Medical College in New Delhi. He completed his doctor of medicine degree at the University of Delhi and was admitted to the membership of the Royal College of Physicians in Great Britain. He served his residency at Southern Illinois University School of Medicine.

Louis Benoist, MD, an orthopaedic and hand surgeon specialist, has joined the Midelfort orthopaedics department. He earned his medical degree from the University of Mississippi in Jackson and completed his orthopedic residencies at Louisiana State University in Baton Rouge and the University of South Alabama in Mobile. He completed a fellowship in hand surgery at the University of Mississippi School of Medicine in Jackson. He is board-certified with the American Board of Orthopaedic Surgery and is a fellow with the American Academy of Orthopaedic Surgeons.

S. Mark Bettag, MD,* has joined the staff of the Sheboygan Clinic in oncology and hematology. He earned his medical degree at Rush Medical College in Chicago, Ill. He completed an internal medicine residency at Loyola University Medical Center. He completed a fellowship in hematology and oncology at the University of Colorado Health Sciences Center in Denver. He is certified by the American Board of Internal Medicine and is a member of the State Medical Society of Wisconsin, the Sheboygan County Medical Society, the American College of Physicians and the American Association of Cancer Research.

Ellen Blando, MD, practicing Family Medicine and Obstetrics has joined Community Memorial Hospital Primary Care in Oconto Falls. She is a graduate of De La Salle Medical School, Phillipines. She completed her Family Practice residency at Flower Hospital, in Sylvania, Ohio.

Roderick Brodhead, MD, joined the staff of the Mercy Walworth Urgent Care Center. He is a fellow of the American College of Emergency Physicians, and graduated from the University of Wisconsin Medical School. He completed a general surgery internship at Gunderson Clinic and Lutheran Hospital in La Crosse.

Joel Bormann, MD,* has joined the medical staff at Midelfort's family practice department. He earned his medical degree from the College of Osteopathic Medicine and Surgery in Des Moines, Ia. He completed his residency in family practice at Martin Army Hospital in Fort Benning, Ga. He is board-certified with the American Board of Family Practice.

Bruce Bragonier, MD, has joined the medical staff at Bay Area Medical Center as an orthopedic surgeon with special training in children's orthopaedics. He recently completed his fellowship under Charles T. Price, MD, in pediatric orthopedic surgery at Orlando Regional Medical Center. He earned his bachelor of science degree and doctor of medicine degree from the University of California-Los Angeles. He also completed his internship and residency training there.

Douglas L. Carlson, MD,* joined the staff of Milwaukee Obstetrics & Gynecology, SC in Wauwatosa. He completed his residency in obstetrics and gynecology at St. Joseph's Hospital in Milwaukee and is a 1985 graduate of the University of Wisconsin.

Ivan J. Chavez, MD,* has joined the staff of Mercy Walworth Medical Center. He is certified by the American Board of Internal Medicine and is a graduate of the University of Illinois School of Medicine. He completed his internship and residency in internal medicine and a fellowship in cardiology at the Medical College of Wisconsin in Milwaukee. He is also a member of the American Medical Association and an affiliate member of the American College of Cardiology.

Theresa Cheng, MD,* has joined the neurosurgery department at Midelfort Clinic and Luther Hospital. She earned her medical degree from the Medical College of Wisconsin in Milwaukee and completed her neurological surgery residency at the Mayo Graduate School of Medicine in Rochester, Minn. She also has a doctorate in neurosciences from the Medical College of Wisconsin.

Joseph J. Cottrell, MD, is the new chief of staff at the Milwaukee VA Medical Center. His previous assignment was as the associate chief of staff for education at the Pittsburgh VA Medical Center and assistant professor of medicine and anesthesiology at the University of Pittsburgh.

Anthony Dalton, MD, an orthopaedic surgeon, has joined Vernon Memorial Hospital's new outpatient clinic. He earned his medical degree from Creighton University Medical School in Omaha, Ne graduating cum laude. He completed his medical residency at the Medical College of Wisconsin's affiliated hospitals in Milwaukee to include an orthopaedic surgery residency as well as radiology.

John B. Feole, MD, *has recently joined the medical staff of Door

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County Memorial Hospital and Diagnostic Imaging of Door County. He completed his training in diagnostic radiology at Rush Presbyterian-St Luke's Medical Center in Chicago, where he also completed a fellowship in nuclear medicine. He is certified by the American Board of Radiology and is eligible for board certification in nuclear medicine. He graduated magna cum laude with a degree in biology from Creighton University in Omaha, Ne. He earned his medical degree from the Creighton University School of Medicine.

Eugene Gonzales, MD,* has joined West Side Medical Center in Beloit as a family practitioner. He earned a bachelor of arts degree in chemistry from Adam State College in Alamosa, Colo. He attended the University of Colorado Medical School in Denver and served his first year of his residency through the University of Colorado in Denver. He completed the last 2 years of his residency in Grand Junction Colo.

Richard Hanna, MD,* a cardiology specialist has joined the cardiology department at Midelfort Clinic. He earned his medical degree and performed his residency in internal medicine at the Medical College of Wisconsin in Milwaukee. He completed a 3-year fellowship in cardiology at the Medical College of Wisconsin. He is board-certified with the American Board of Internal Medicine and board-eligible with the American Board of Cardiology.

Judith Harpenau, MD, has joined the family practice department of the Franciscan Skemp Healthcare in LaCrosse. She received her undergraduate degree from Viterbo College, La Crosse and earned her medical degree from the University of Iowa College of Medicine in Iowa City. She completed her residency at Cedar Rapid's Family Practice Residency Program, Cedar Rapids, Ia.

Cyril M. Hetsko, MD,* was reelected American Society of Internal Medicine Trustee. He is a practicing internist in Madison, subspecializing in infectious diseases and has served on the ASIM Board of Trustees since 1991. Doctor Hetsko is president-elect of the North Central Medical Conference, a member of the AMA Council on Medical Service, and past president of both the Wisconsin Society of Internal Medicine and the State Medical Society of Wisconsin. He is affiliated with the multispecialty Dean Medical Center, and is a professor of medicine at the University of Wisconsin-Madison.

Susan J. Layeux, MD, a family practitioner, has joined the medical staff of Waukesha Medical Centers-Hartland. She graduated from the Medical College of Wisconsin. She completed her family practice residency at the Maine-Dartmouth Family Practice Residency in Augusta, Me.

Gary Leong, MD, practicing family medicine and obstetrics, has joined Oconto Falls Community Memorial Hospital Primary Care. He earned his medical degree at the University of Calgary, Canada and completed his residency in Family Medicine at the University of Alberta in Edmonton.

Jose Adie E. Lim, MD, an internist, has joined the staff of the Memorial Medical Center. He earned his medical degree from a medical school in Manila and completed his 3-year residency program at the Cook County Hospital in Chicago.

S. Bert Litwin, MD,* director of Thoracic and Cardiovascular Surgery at Children's Hospital of Wisconsin and clinical professor of Surgery at the Medical college of Wisconsin, authored the Color Atlas of Congenital Heart Surgery. It will be available to the public on Dec 8, 1995. The atlas contains more than 600 dramatic operative photographs, line art, and instructive text. The photographs demonstrate common and rare congenital heart defects. They were taken during Litwin's 27 years of surgical experience. In the atlas, Doctor Litwin shows his preferred techniques and operative solutions for the most complex surgical procedures to correct heart abnormalities.

Lawrence Markovitz, MD, has recently joined the cardiovascular surgery department Midelfort Clinic and Luther Hospital. He earned his medical degree and completed his residency in general surgery at Mount Sinai School of Medicine in New York. He completed a residency in cardiothoracic surgery at the Hospital of the University of Pennsylvania in Philadelphia. He is a fellow with the American College of Surgeons, the American College of Cardiology and the American College of Chest Physicians.

Kermit Newcomer, MD,* formerly of the Gundersen Clinic in La Crosse, has been hired as a consultant by the American Medical Association. He will begin Nov 1 as a physician liaison with the group practice community. He recently retired from the practice of internal medicine and nephrology. He has served in the AMA House of Delegate representing the American Group Practice Association.

M. Pajeck, MD, a primary care physician has joined Covenant Medical Group. He earned his medical degree from the Medical Academy of Gdansk and completed a 1-year internship and an internal medicine residency program at St. Luke's Hospital in Bethlehem, Pa.

Morris Pasternack, MD, pulmonary disease specialist, has joined Midelfort Clinic and Luther Hospital. He earned his medical degree at Boston University School of Medicine and completed his residency in

internal Medicine at the University of Iowa Hospitals and Clinics in Iowa City. He completed a 3-year fellowship in pulmonary disease and critical care medicine at the University of Iowa.

Herbert F. Sandmire, MD,* obstetrician and clinical professor was selected as the first recipient of the Special Recognition Award presented by the Wisconsin Section of the American College of Obstetricians and Gynecologists. The award was developed as the college's highest honor, and will be issued at infrequent intervals and only for unusual and outstanding contributions.

Michael Seitzinger, MD, * gynecologist, has joined the medical staff of Community Health Network and Berlin Memorial Hospital. He is a graduate of Tulane School of Medicine in New Orleans, La. He is board certified by the American Board of Obstetrics and Gynecology. He completed a 4-year residency and 3-year internship in obstetrics/gynecology at Oakwood Hospital in Dearborn, Mich.

Grigory Sorokin, MD, * has joined Milwaukee Medical Clinic as an internal medicine specialist. He completed his residency in internal medicine at the Medical College of Wisconsin Affiliated Hospitals and earned his medical degree from the Medical College of Wisconsin.

Catherine Swanson, MD,* a family practitioner, has joined the Associated Family Physicians of Berlin and Wautoma. She is a graduate of the University of Iowa College of Medicine in Iowa City. She completed a 3-year Family Practice residency at the Medical Center Hospital of Vermont, in Burlington, Vt. During her residency she has received training in obstetrics, outpatient surgery, outpatient orthopaedics, geriatrics and colposcopy at Brown University.

Laura J. Tombino, MD, orthopaedic surgeon, has recently joined Duluth Clinic. She earned her medical degree from Northwestern University. She completed her internship and residency in orthopaedic surgery and a fellowship in pediatric orthopaedic surgery at the University of Iowa Hospital and Clinics. She is certified by the American Board of Orthopaedic Surgery, a fellow of the American Academy of Orthopaedic Surgeons and a member of the Pediatric Orthopaedic Society of North America.

Marvin Wagner, MD, * professor of cellular biology and anatomy, received a Distinguished Service Award from the Milwaukee Academy of Medicine on October 17. He was honored for his 45 years of service to the Medical College. A clinical professor of surgery and adjunct professor of cellular biology and anatomy, he has taught many medical students and residents. He also developed an active research program in anatomy and surgery.

David Winter, MD,* radiologist, has joined Luther and Midelfort's medical imaging department. He earned his medical degree from the University of Minnesota in Minn and completed his residency at the University of Wisconsin Hospital and Clinics in Madison. He is board-certified with the American Board of Radiology and he completed a body imaging fellowship at the University of Wisconsin.

Jake S. Vacarella, MD, pediatrician, has joined the Mercy Walworth Medical Center. He is a graduate of the University of South Alabama School of Medicine, completing an internship and residency in pediatrics at the University of Alabama Medical Center and the Children's Hospital of Alabama.

Ravinder Vir, MD, has joined Duluth Clinic-Hayward Medical Group as a general internal medicine specialist. He earned his bachelor of medicine and bachelor of surgery degree at Maulana Azad Medical College, University of Delhi in New Delhi, India. He completed a rotating internship at Maulana Azad Medical College and its associated LNJPN and GB Pant Hospitals and a residency in medicine at LNJPN Hospital. He completed a residency in pediatrics at Sanjay Gandhi Memorial Hospital after which he did postgraduate training in Chest Diseases at VPCI, University of Delhi. He is board eligible in internal medicine.❖

Obituaries

Karsten, Fred, A., MD, of Horicon, died Sept 7, 1995. He attended the University of Wisconsin and graduated from Hope College in Holland, Mich., and Marquette University Medical School. He served in private medical practice in Horicon from 1958-1992, marking 100 years of Karsten medical practice in Horicon. He was a Fellow of the American Society of Industrial Physicians, and served as a former Chief of Staff at the Lutheran Hospital, Chief of Emergency Services at the Beaver Dam Community Hospital, Medical Director of county institutions and Clearview Nursing Home, Medical Director of the Beaver Dam Care Center, and Medical Director of the John Deere Horicon Works. He is survived by his wife Kathleen, five children, John Karsten of Waupun, Adrian Karsten, of Horicon, Mary Karsten, of Evanston, Ill, Jennie Patrykus, of Horicon, and Carrie Karsten, of Wauwatosa, and three grandchildren.

Rodgers, Richard, E., MD, of Brookfield, died September 4, 1995. He graduated from Illinois College, Phi Beta Kappa and graduated from the University of Chicago School of Medicine. He was chief of surgery at Sinai Samaritan Medical Center. He was assistant director of the Renal Transplant Service of the Medical College of Wisconsin. He is survived by his wife, Ann, and two children, a son Gregory of Scottsdale, Ariz, and a daughter Elizabeth Butler of Menomonee Falls and one grandchild.❖

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.❖

County medical society news

Ashland-Iron-Bayfield. The Ashland-Iron-Bayfield County Medical Society approved membership for Stephen Kreuser, MD; Jeffrey Lewis, MD; and Katherine Parkinson, MD.

Door-Kewaunee. The Door-Kewaunee Medical Society approved membership for James M. Lewis, MD; James V. Tobin, MD; and Ma Caridad Rosal, MD.

Fond du Lac. The Fond du Lac County Medical Society approved membership for Dwight A. Wigg, MD; Aniruddha Deshpande, MD; and Thomas Schneider, MD.

Green Lake-Waushara. Catherine Swanson, MD; and John Zwiacher, MD, have been approved for membership in the Green Lake-Waushara County Medical Society.

Jefferson. The Jefferson County Medical Society approved membership for the following physisians: Donald E. Bates, MD; Alan L. Detwiler, MD; Daniel R. B. Fary, MD; Edwin D. Fischer, MD; Edgardo C. Jiongco, MD; Paul J. Neary, MD; David A. Rutledge, MD; Geoffrey L. Smith, DO; and Thomas J. Tackman, MD.

Kenosha. The following physicians have been approved for membership in the Kenosha County Medical Society: George N. Geotsalitis, MD; Robert H. Johnston, Jr, MD; Joshua A. Bloom, MD; and Arthur K. Kennedy, MD.

La Crosse. The La Crosse County Medical Society approved membership for William A. Agger, MD; Nicholas Y. Lorenzo, MD; JoAnn E. Ormand, MD; James R. Singer, MD; and Gary A. Susag, MD.

Manitowoc. The Manitowoc County Medical Society approved membership for Andrea J. Carroll, MD; Orion C. Whitaker, III, MD; and Christopher Keller, MD.

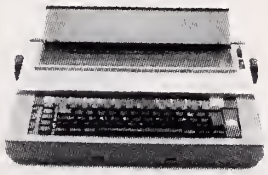
Milwaukee. The Medical Society of Milwaukee County approved membership for the following physicians: Sundeep Das, MD; Julie A. Fuller, MD; Patrick J. Fuller, MD; James M. Garrity, DO; Lynn M. Gilles, MD; Mark L. Leitschuh, MD; Leslie A. Man, MD; Patrick J. Mroczkowski, MD; Noe Neaves, Jr, MD; John A. Obudinski, DO; Niraj Sawhney, MD; Jeffrey T. Van Dermark, MD; Dean W. Ziegler, MD; Syed Ahmed, MD; Shamsuddin Akhtar, MD; Ahmad B. Al-Hamda, MD; Hossein Amirani, MD; Padmaja Doniparthi, MD; Estelle S. Fletcher, MD; Gregory A. Francken, MD; Sandra L. Gage, MD; Marianne Geiger, MD; Sudarshan R. Jadcherla, MD; Judy E. Kim, MD; Paul M. Lemen, MD; Sangeeta Logani, MD; Jose Paulo Lorenzo, MD; Kevin S. Madigan, MD; Genevieve Obrochta, MD; John M. Oscherwitz, MD; Sharyl G. Paley, MD; Peter G. Parrino, MD; Dena E. Petersen, MD; Eric A. Postel, MD; Nadine F. Potempa, MD; Fedja A. Rochling, MD; Bruce E. Rowe, MD; Shakti Sudha Sabharwal, MD; Timothy N. Schuchard, MD; Elizabeth E. Scott, MD; David A. Severance, MD; Juan Carlos V. Soliven, MD; David M. Staff, MD; Brent G. Thiel, MD; Beth A. Trost, MD; and Joy O. Urubusi, MD.

Ozaukee. Nancy A. Boelter, MD, has been approved for membership in the Ozaukee County Medical Society.

Rock. The Rock County Medical Society approved membership for Christiane Tabatzky, MD; and Benita J. Walton, MD.

Sheboygan. The Sheboygan County Medical Society approved membership for Todd M. Bradshaw, MD; Elena Gorlovsky, MD; Badri Ganju, MD; and Mark Bettag, MD.

Waupaca. The Waupaca County Medical Society approved membership for Richard P. Reigel, MD; and Safir U. Shaheen, MD.❖



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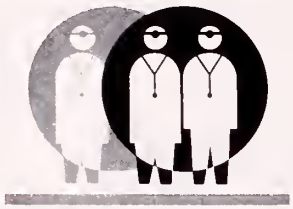

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MADISON, WISCONSIN - URGENT CARE. Dean Medical Center, a 350+ physician multispecialty group, is seeking a full time physician to assist in staffing our two urgent care centers. Qualified applicants should BE/BC in Family Practice, Emergency Medicine or Internal Medicine with experience in Pediatrics. Dean Medical Center operates two Urgent Care Centers 365 days per year, from 7:00 a.m. - 10:00 p.m. All physicians employed at the urgent care centers are paid on an hourly basis, and full time physicians are eligible to buy into the corporation after two years of employment. Excellent compensation and benefits. Contact Scott Lindblom, Dean Medical Center, 1808 W. Beltline Highway, Madison, Wisconsin, 53715-0328, 1-800-279-9966 or (608)250-1550 or FAX (608)250-1441. 11-12/95;1-3/96

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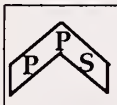

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MADISON, WISCONSIN. Dean Medical Center, a 350+ physician, private, multi-specialty group, is actively recruiting a BE/BC internist to join our Dean Clinic (our main building) on Fish Hatchery Road in Madison. The Fish Hatchery Road, Middleton, and our West Madison Clinic share a call schedule which is approximately a one in ten call schedule. A two year guaranteed salary plus incentive and benefits is being offered for this position. For more information contact Scott M. Lindblom, Medical Staff Recruiter, Dean Medical Center, 1808 West Beltline Highway, Madison, Wisconsin, 53713, work (608)250-1550, home (608)833-7985 or fax (608)250-1441. 11-12/95,1/96

JANESVILLE, WISCONSIN. Dean Medical Center, a 350 physician multi-specialty group, is actively recruiting additional BE/BC family physicians to practice at the Riverview Clinic locations in Janesville, Milton and Delavan, Wisconsin. Janesville, population 55,000, is a safe, beautiful, family oriented community with excellent schools and abundant recreational activities. Excellent compensation and benefits are provided with employment leading to shareholder status. Send CV to Stan Gruhn, MD, Riverview Clinic, P.O. Box 551, Janesville, WI 53547, or call (608)755-3500. 11-12/95;1-10/96

PLATTEVILLE, WISCONSIN. Dean Medical Center, a 350+ physician private multi-specialty group is actively recruiting a BE/BC internist to join their affiliated Doctors Park Clinic in Platteville, Wisconsin (population 10,000). The current staff consists of four family practice physicians, one general surgeon and three physician assistants. Each physician works 4-1/2 days per week, sees approximately 25 patients per day. A minimum $115,000 guaranteed salary plus incentive is provided. There is also a loan forgiveness program being offered for eligible physicians. For more information, contact Scott M. Lindblom, Medical Staff Recruiter, Dean Medical Center, 1808 West Beltline Highway, Madison, Wisconsin, 53713, work (608)250-1550, home (608)833-7985 or fax (608)250-1441. 11-12/95;1/96

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WISCONSIN - Unique opportunity for a board certified or prepared Family Practitioner to practice as part of the Oak Leaf Medical Network, a "group practice without walls" consisting of 75 physicians in the greater Eau Claire, Wisconsin area. The practice includes a competitive compensation package and comprehensive benefits. Eau Claire, located in gorgeous northwestern Wisconsin, offers a wide variety of recreational and cultural activities, including watersports on both the Chippewa and Eau Claire Rivers, which provide a beautiful environment in which to live and work. For more information, contact Steve Baker at 800-430-6587 or fax your CV to 309-685-2574. 10-12/95

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EMERGENCY MEDICINE: WISCONSIN. Be a partner in your own democratic partnership in family oriented communities close to Milwaukee. Low volume ED's. Medical Director, Full-time and Part-time positions available. Call 414-332-6228 or send CV to the Emergency Resources Group, 509 West Montclaire Avenue, Milwaukee, Wisconsin, 53217. 9/95-2/96

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Medical Meetings - Continuing Medical Education

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32nd Indianhead Symposium & Ski Meeting - WAFP
Mayo Faculty, Lakewoods, Cable, WI
Contact: A. Lagus, MD, 1-800-828-3627
11-12/95

February 8-9, 1996
20th Annual Winter Pediatric Seminar
Indianhead Mountain Resort
Wakefield, MI
Contact: Marshfield Clinic, Office of Medical Education, 1000 North Oak Ave, Marshfield, WI 54449, 1-800-541-2895.
11/95-1/96

Medical Meetings - Continuing Medical Education
Continued

February 29-March 1, 1996
Practical Strategies in the Evaluation and Management of the Geriatric Patient
Indianhead Mountain Resort
Wakefield, MI
Contact: Marshfield Clinic, Office of Medical Education, 1000 North Oak Ave, Marshfield, WI 54449, 1-800-541-2895.
11/95-1/96

February 28 - March 2, 1996
The Medical College of Wisconsin and the University of Wisconsin Medical School will sponsor its third bi-annual "Wisconsin Board Review Course in Geriatric Medicine" on February 28 - March 2, 1996, at Lake Lawn Lodge in Delavan, Wisconsin (just outside Lake Geneva.) This intensive training course will be an in-depth review of the field of geriatric medicine, designed to assist physicians who will be sitting for the Certificate of Added Qualification examination in Geriatric Medicine. It will also serve to assist clinicians who wish to provide better care to their geriatric patients. Course participants will be exposed to principles of aging such as demography, biology and physiology, and the clinical approach to the geriatric patient; and major syndromes such as dementia, incontinence, falls, and metabolic bone disease. Special emphasis will be placed on geropsychiatry, social/reimbursement issues, and systems of geriatric care, including long-term care and geriatric assessment. Organ-specific diseases that have special import for the geriatric patient will also be reviewed. Finally, an optional workshop focusing on the principles of multiple choice examination tests and strategies to complete these examinations efficiently will be given. Enrollment will be limited. Clinicians interested in reserving a spot or obtaining further information should contact Penny Romasko ad (414)384-2000, X-2775. 12/95-1/96

IM BOARD REVIEW COURSE - Excellent passing record. San Diego 2-17 to 2-21-96; St. Louis 4-10 to 4-14-96; Newark, NJ 6-26 to 6-30-96; Columbus, OH 7-31 to 8-4-96. Call voice mail (614)631-2756 or write to IMBRC, 5892 Whitestone Drive, Columbus, OH 43228.
12/95;1-3/96

Miscellaneous

BIRCHBARK CANOE BUILDING COURSE. June 29-July 14 or July 20-August 4, 1996, Lake Superior (Wisconsin shore). "Total immersion in birchbark canoe construction," Lorenzo Carcereri, MD (Italy). "Absolutely delightful," Lawrence Manion, MD (New York). Information: David Gidmark, Dept. 11, Box 26, Maniwaki, Quebec J9E 3B3.
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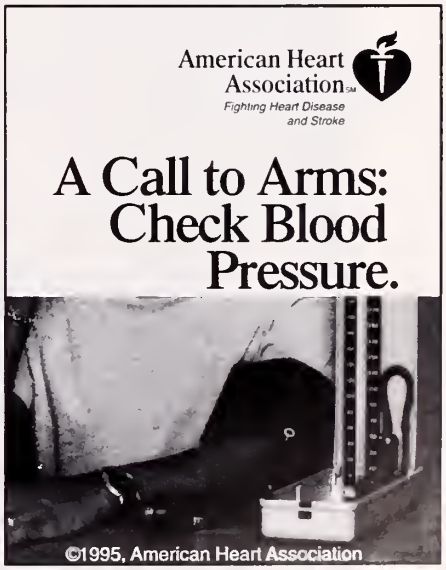

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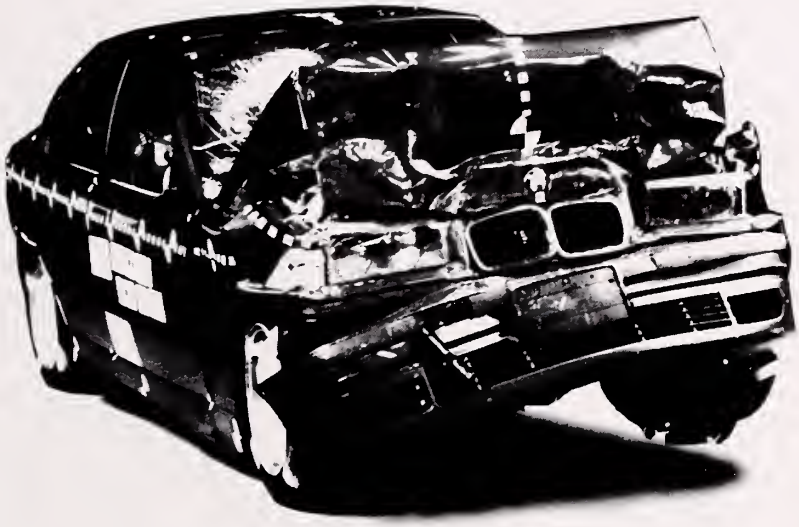

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